VOL. VI. JANUARY, 1899. No. 1.

CATALOGUED APR 24 1902 E. H. B.

The Tri-State Medical Journal

and

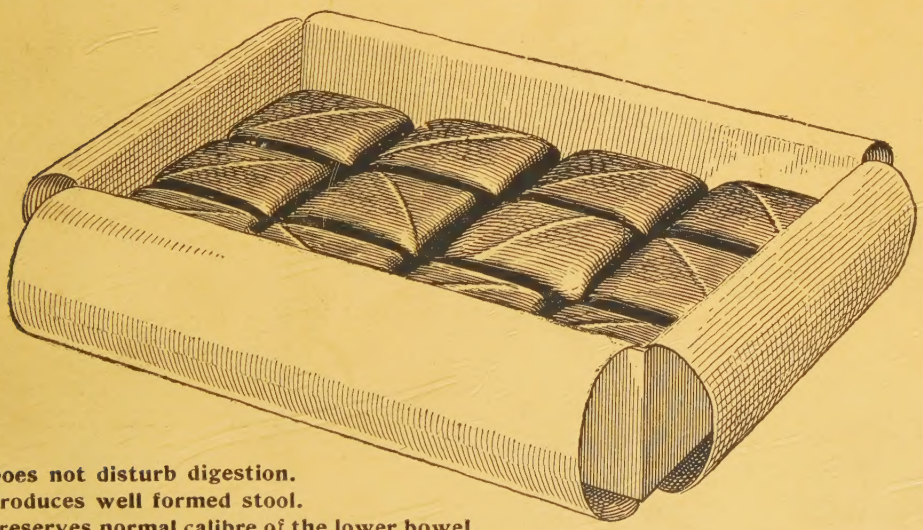
Practitioner.

BOSTON MEDICAL LIBRARY AUG 9 1899

ENTERED IN THE POST-OFFICE AT ST. LOUIS, MO., AS SECOND-CLASS MATTER.

"FIKULAX" (Ficus Chocolatis Laxans) is presented as a laxative which causes a gentle, alvine evacuation without irritation. Most valuable in habitual constipation.

FIKULAX is delightful in taste and attractive in appearance, important attributes in a medicament to be administered to women and children.



Does not disturb digestion.
Produces well formed stool.
Preserves normal calibre of the lower bowel.

CHAS. ROOME PARMELE CO., 36 PLATT STREET, NEW YORK.

TABLE OF CONTENTS, PAGES VII AND VIII.

Predigested Beef

Is the basis of **Armour's Nutrient Wine of Beef Peptone,** a preparation presenting the entire digestible substance of prime, lean Beef, in a form requiring no effort of the digestive organs to render it diffusible.

Nutrient Wine

Is especially indicated in the treatment of all cases of faulty nutrition occasioned by gastric weakness, Ulceration of the Stomach, Phthisis, Typhoid Fever, and wherever a readily assimilable food is required.

Manufactured by

ARMOUR & COMPANY, CHICAGO.

BOSTON MEDICAL
MAR 27 1908
LIBRARY

11020

THE TRI-STATE

Medical Journal and Practitioner

VOL. VI., NO. 1. JANUARY, 1899.

Issued Monthly for One Dollar a Year.

EDITORIAL DEPARTMENT.

WARREN B. OUTTEN, M. D., - - - - - EDITOR.
JAMES MOORES BALL, M. D., - - - - } ASSOCIATES.
R. C. BLACKMER, C. M., M. D., - - - - }
OTHO F. BALL, M. D., - - - - - BUSINESS MGR.

Address all communications, news of medical interest, subscriptions, etc., to the TRI-STATE MEDICAL JOURNAL AND PRACTITIONER, 3509 FRANKLIN AVENUE, ST. LOUIS, MO.

NATIONAL PUBLIC HEALTH LEGISLATION.

The intelligence of the country appears to be with any measure of sanitation looking towards the prevention of disease and particularly combating actual infection. But it would seem that the intelligence of the country accomplishes very little in this direction for the formation and execution of permanent and well-directed measures. Such individuals as Col. Geo. E. Waring and Dr. Leonard Wood accentuate what can be accomplished by intelligent and well-directed effort. National public health legislation lags and year by year reaches a state of discussion, to die of lack of push from the nation's legislators.

Dr. U. O. B. Wingate, in a recent number of the *North American Review*, discusses this question well and intelligently. He favors a measure now before Congress known as the Spooner bill. It provides for a national commission of public health which shall be a bureau in the treasury department, the duties of which shall be to collect and disseminate information with regard to the prevalence of infectious diseases in this and other countries; to collect and publish vital statistics; to prepare rules and regulations for securing the best sanitary condition of vessels from foreign ports, and for preventing the introduction of infectious diseases into the United States, and their spread from one State or Territory to another; in short, to make investigations, publish information and formulate rules with a view to the preservation of the public health. The bill provides that the commission shall co-operate with existing authorities and supersede them except in the presence of an epidemic, when the local authorities are unable to cope with the disease or show inefficiency. The National Commission of Public Health shall be composed of a commissioner, a representative from each

State and territorial board of health, and a representative each from the medical corps of the United States Army, Navy and Marine Hospital Service; an executive committee of eight is provided for. It will be seen from this that the Spooner bill is a very cumbersome affair, and no doubt would be the source of very much expense, and we doubt as to whether a board of forty or fifty men could be wielded efficiently. The best illustrations which we have ever seen of real worthy and efficient sanitation have come from the single, competent and strong executive. We would much rather trust Dr. Leonard Wood at the head of a working corps than this multitudinous commission. No! the Spooner National Commission of Public Health, while it is far-reaching, is too much like a medical society—there would be too much talk and not enough done.

THE TRAILING SKIRT.

We notice in a recent issue of one of the lay journals a few thoughts upon the unsanitary and danger-producing elements of the long and dragging skirts of the ladies. The anonymous correspondent very witheringly says: "I suppose the love of women for something trailing behind them is a reminiscence of that remote state of human development when the spinal column had an appendix dangling down behind; this supposition appearing more probable by the fact that the women of some African tribes at the present time tie the tails of cows to their back, and she who has the longest tail trailing behind her is the proudest and most envied one of her sex."

There is no doubt as regards the unsanitary elements of long and dragging skirts; still we do not believe, like this correspondent, that it is a death-dealing agent to the world surrounding. That dust, with its compound elements of septivity is dangerous when stirred up, cannot be doubted; that a long skirt is a means of stirring up the bacillus tuberculosis promiscuously distributed by various sufferers upon floors and streets, and is competent to do the same, is equally true; but the relative infrequency of this cause makes a very mild death-dealing agent, and one not likely to menace public health very ponderously. That the trailing skirt is slovenly and filth-engendering, there can be no doubt; that under certain conditions it is unsanitary to the wearer and to others, there can be no doubt; but we do not believe it necessary to use a national health commission to combat it. Fashion seems to be a potent agent to take from the trailing skirt its death-dealing sting, for fashionable women rarely wear any dress long enough to make even a trailing skirt a menace.

FIGHTING THE OSTEOPATHS.

The Iowa State Board of Medical Examiners is to be complimented on its attitude toward the pseudo science called osteopathy. Regardless of the existence of a law apparently legalizing osteopathy, the Board has decided that the schools of osteopathy do not come up to the requirements of the Iowa medical law which the last legislature passed, and which went into effect on the first day of January, 1899.

A recent dispatch from Des Moines says:

"The State Board of Medical Examiners completed its work and adjourned Thursday. Before doing so it took another step in the osteopathic

fight. It was a decidedly forward move. A series of stringent rules was adopted, in which the board defines just what, in its view, the law meant by "a regularly conducted school of osteopathy." Members of the board who conversed upon the subject yesterday declared that they would welcome legal action on the part of those practicing osteopathy, for the result would be an interpretation of what the law meant, and that was just what they were trying to secure.

"President Scroggs stated that he had sought legal advice upon the subject, and he had been assured that the position of the board was unassailable. He believed that it was essential to the interests of the people of Iowa that, if the practitioners of the new school were permitted to engage in the practice of medicine in the State, the people should be guarded against quacks who, under the guise of something new, use their blandishments to wheedle people out of money. There are any number of irresponsible schools in the country, he said, sailing under the title of osteopathy, and the number of graduates coming from these institutions is marvelous. It was certain, he thought, that genuine osteopaths were being imposed upon. Regularly conducted scholars, who had put in the required time and had taken up the studies demanded by law, should be protected. That was the reason why the board took the action it did.

"The regulations adopted are very stringent. There is not a school of osteopathy in the country which would come within the requirements laid down by the board. The board followed the same lines used in determining whether a medical college comes up to the standard or not, with the exception of a change in the studies prescribed for students."

We hope that the position of the Board is unassailable, and that Missouri may soon be rid of its bone doctors and boneset governor.

INSTANT DEATH IMPOSSIBLE.

We notice in the lay press this question discussed with all due seriousness—that biological analysis seems to show that even decapitation cannot at once end human life. It is said that if we can differentiate between dead and live brain cells, we can more easily ascertain how long a time elapses before the death of the cell takes place. No one has proved as yet the difference between a dead and a live brain cell. This reminds us of the proposition, if the cell be round, how on earth can it come to an end? It is asserted that in both plants and animals, while they differ widely in their external appearance, they are fundamentally similar in structure. In the study of the cell the botanist, the zoologist, the physiologist, and the pathologist, go hand-in-hand. In the study of cellular elements the cell is the final element. As Virchow has expressed it, it is the vital elementary unit. From this point of view all the vital processes of a complex organism appear to be nothing but highly-developed results of the individual vitality of innumerable fundamental cells. If such is the true fact, how is it possible, by simple decapitation, to cause instant death in the millions of cells which compose the brain? It is claimed that each brain cell has its own life and is able to live a certain time after being cut off from outside nutrition. It appears to us that this individual cellular life is a mask for much that is indefinite and fictitious, inasmuch as no one has

seen a brain cell act under its true and essential vital conditions; things even under a microscope look really different from what they are. It is asserted that every brain cell does not die simultaneously with the body; that in certain diseases the brain cells are the last to die, and that they live a certain period of time after outward manifestation of death—for some hours—that is, we may have somatic death and molecular life. In the discussion of such subjects we are often led to the thought as to their relative value. A headless trunk, a decapitated head, are valueless, except for discussion; and it seems to us that is the only real purpose and use they can be put—to tickle the vanity of the general discusser. A man's brain cells may not be dead when a head is decapitated, but, like Mercutio's wound, it is ponderously and profoundly sufficient. Such discussions levy a tax upon each brain cell to fatuitously stir its extra convoluted mass. There is little benefit to the decapitated man to have his brain cell put under a microscope. While a man may not lose his identity when parting with his head, still he has lost about all that is of any especial value to him.

QUININE—AN EPITOMIZED STORY.

It was not until 1815 that cinchona bark was analyzed, and five years elapsed before the alkaloid quinia was found in it. It is stated of the Peruvian bark, only one-fiftieth comes from Peru, and that its chief source of supply being Madras—Ceylon holding second place; the two together supplying more than all the rest of the world put together. Peruvian bark first came into notice in 1638, when the Countess Cinchon, wife of the viceroy of Peru, lay ill at Lima of a tertian ague. Her physician was sent by the corregidor of Lona some of the bark, he having heard its virtues extolled, which, on being administered, brought the countess to a complete and rapid cure. Two years afterwards the countess returned to Spain, taking with her a supply of the bark for the use of the sick on her husband's estates. Under the name of the countess' powder its good reputation gradually extended. In the year 1670 the Jesuits sent some parcels of the powdered bark to Rome, which was distributed by Cardinal De Lugo, and it became known as cardinal's powder, Jesuits' bark; it is stated that in consequenc of its receiving such names that no Protestants would have anything to do with it. It is mentioned that at a very early period a monopoly was attempted, which, for the time being, was highly successful. The story runs thus: The Jesuits persuaded the Pope to draw a line across South America, beyond which no tree should be recognized as yielding quinine. No matter whether it was better bark the Popes line made its virtue and any one doubting became a heretic. The Jesuits for a time monopolized the sale of this bark, particularly in Catholic countries; they lauded it to the skies, calling it an infallible remedy, under the name of pulvis patrum. John Talbor, an English apothecary, probably did more than any single person to establish the virtues of this remedy. He effected a great number of cures without revealing its name. Peruvian bark certainly made John Talbor, for in 1687 he was knighted by Charles II., the next year he became physician-in-ordinary, owing to having cured Charles II. of tertian fever. John Talbor was energetic. He went over to France, where he cured the Dauphin and other personages in high and

lofty places, but finally sold the secret of its preparation to Louis XIV. for two thousand *louis-d'or*, a pension and a title. John beat the Jesuits. Notwithstanding Talbor's success, the doctors fought this new remedy bitterly; some Parisian physicians averring that the new remedy was responsible for ninety sudden deaths in Madrid, alone. Still, amidst all opposition, it made its way, helped along by the powerful aid of Sydenham and Morton. The rest need not be told.

THE BARBER-SURGEONS OF ENGLAND.

In early times the clergy monopolized the practice of all branches of medicine. The monks devoted so much time to its practice that their religious duties were neglected and it became necessary for the church to take action thereon. The Lateran Council, in 1139, forbade the practice of physic by the monks. The eighth canon promulgated by the Council of Tours, in 1163, forbade monks staying out of their monasteries longer than two months at a time, and prohibited their teaching or practicing physic. No such restraint was placed on the secular clergy, and for many years dignitaries of the church were physicians-in-ordinary to kings and princes. Many of these reverend doctors were educated at Salernum and much of their knowledge came from reading the writings of the Arabians. In 1215 an ordinance of Pope Innocent III. forbade the ecclesiastics practicing any operation, for the reason that the church "abhorret a sanguine." Two later decrees, one by Boniface VIII., at the end of the thirteenth, and the other by Clement V., early in the fourteenth century, formally separated surgery from physic, and the practice of surgery was absolutely forbidden to the priests. Thus, surgery was turned over entirely to the laity, and barbers became its practitioners. The better class of barbers received instruction from the priests, assumed the title of barber-surgeons, improved themselves by making dissections, and, freeing themselves from the barbers, became a fraternity of surgeons.

EMOTIONAL EFFECT OF COLORS.

We have recently read in the lay press the most weird and startling effect which colors produce upon the emotions. The article speaks of the series of experiments now being conducted by Dr. William S. Wadsworth, assistant professor of physiology in the University of Pennsylvania. The article is introduced by a very effective prelude, by showing all cultivated people are lovers of fine music. Why he should say cultivated, we do not know, since we believe that lovers of music are not confined to the cultivated alone. That they at once appreciate the different emotional effects produced by the squeaking bag-pipe march and the dreamy, soothing cadences of Schubert's serenade. It is averred that certain combinations of sound drive men to battle and others lull them into sweet content and peace. But it has rarely occurred to the most thoughtful that the discords of color are more harrowing to the soul than the discords of sound. The eyes receive restfulness and restlessness from colors, according to their varied tints. In order to still further accent the hideous agony produced upon the emotional souls of persons he says: "The worst form of torture which the 'purple East' has ever devised has been by that color. The

twelfth grade of initiation into the Buddhist mysteries, the perfection of 'astral' education, so graphically described by A. Conan Doyle in 'The Mystery of Cloomber,' is the so-called 'color-test.' The neophytes are ushered into an extensive and lofty room, and at a given signal the whole surrounding space is flooded with an excruciating tint of purple light. It is reported by reliable witnesses that not more than three-quarters of those thus passed in are alive at the end of several hours, and that all of the survivors are more or less frenzied. When one is thoroughly exhausted the eyes are invariably blood-shot." Yet, if this be true, then, indeed, the world has existed in darkness for a long time. Now, then, inasmuch as they are using electrocution as a merciful means of death, and it would appear that the process is attended with such horrible concomitants, why not put these people in a space flooded by an excruciating tint of purple light? It might be possible, by increasing its excruciating element, to have it act as instantaneous as electricity. It would be an æsthetic means of execution; no smell of burning hair or flesh. The writer of the article goes on to state that while in the laboratory the doctor gave him a little bottle of purple liquid, and he was told to hold it up to the light and keep his eyes fixed on it. He says that at first it fascinated him; then it dazed him; it irritated; then it harried him, and he could stand it no longer. We wonder how this gentleman would do before a drug store, where we see those big, colored show-bottles, with a bright electric light behind them? We are free to confess that we have never seen anybody fascinated, then dazed, then irritated, to be finally harried by these brilliant advertising means of the druggist. A barber's pole is in danger of being a pathologizing agent, and some soap-maker's signs will be causing more than fits. He further says that a carefully-prepared fluid, filled with a particular shade, had a very peculiar effect, for he no sooner held it up before a nervous spasm went through him from head to foot—a regular cold chill. The doctor laughed when this happened, and said: "Oh, it gives you a spasm, too; well, I have touched your key-note." We have heard of people looking through glass too often having spasms. It must have been awful strong for one look to have done all this. He says blue glass is tuned to blue vibrations, so he would have a fiddle or piano tuned with blue, in order to get the proper effects when playing "Saul's Dead March." "Strike a certain note on the piano, and your dog howls." If you strike a hundred he'll howl, because it is his nature to. "Strike another, and a wineglass standing upon the table is shattered." Keeping such powerful note-pianos in the house must be expensive, or they must be peculiar pianos; for if all pianos did this there would be many shattered glasses. "Strike still another, and the gas flares up." How about the electric light? If these colors produced such profound effect, a modern dry goods store should be a regular holocaust fiend. If colors make the emotions ragged and neurasthenic, we have certainly lived among unknown enemies for a long time. It is only a blind man whose emotions are safe. All men, at one period or another, have had their emotions powerfully aroused by color, particularly if they enshrouded the sweetest thing on earth. We would much rather believe the assertions concerning color as found in the old sayings than the new emotionalism of color. Now, there is some truth in this assertion: "Red is love's color," said the red-headed man to his red-headed sweet-

heart; or, "He is false by nature that has a black head and red beard." Blue eyes say: "Love me, or I die;" black eyes say, "love me, or I'll kill thee." Anyhow, color is only skin deep; for black cows and black hens have white products, which is truer than excruciating tint of purple light producing death. Since the prosecution of Christian Science, we believe that only two things are needed to make any inanity grow—suggestion and hysteria.

THAT ANCIENT AND STILL THIS MODERN ENIGMA.

It is asserted that not one doctor in a hundred could in an off-hand manner give anything like a comprehensive definition of hysteria: and yet it would indeed be an ignoramus who could not recognize it. Hysteria has been in the mind and on the tongue of the medical world for over two thousand years, and it gives promise of going on in its consideration for two thousand more; for the medical world is industriously and actively now engaged in striving to elucidate some of its intricate points. It is claimed that Foreslus was the first physician to distinguish it from syncope, apoplexy, epilepsy, etc., and thus commence the work towards establishing this trouble as a well-rounded, morbid entity. We suppose that Sennertus, having seen the by-play of excessive emotionalism engendered in persons during wars and periods of excitement, when individual after individual became hysterical, concluded that it was an infectious trouble. Hippocrates and Plato held that fanciful doctrine of the wandering womb. From the light as shown in Platos study of hysteria, we are compelled to say: "Plato, thou reasoneth wrong." This old landmark of reason Mr. Plato said that the womb was an animal, which desires ardently to engender children. When it remains sterile, it (this big brained womb) controls itself with difficulty (for it just gets mad to the roots of its hair); it is indignant, wanders about the body, obstructing the air passages, arresting respiration, throwing the body into extreme dangers, and causing diverse maladies. According to Mr. Plato, the womb just became a sort of an ambulatory, automatic paranoiac; a kind of boss tramp overseer; a wandering Jew sort of a thing.

Aretæus has always aroused in us, in consequence of his views on hysteria, a desire to picture him; hence, we love to let our imagination run riot as regards how he appeared. A dignified old fellow in flowing toga, sharp-eyed, alert, big nose, pointed chin, eyes watery, and would have worn spectacles had, they existed; a kind of mixture of an Oscar Wilde and Max Nordau order—a touch of Nordau's wonderful scientific love, with plenty of Oscar Wilde's putrid imagination. For Araetus accepted the incredible doctrine that the womb was an animal within an animal; just living in ecstasy, letting its passionate heart throb in the enjoyment of delicate orders. He gave the womb what the foot has not got—a nose; and averred, with all due solemnity—that solemnity which comes from rare scientific knowledge—that it was possible to drive the womb down by presenting odors to the nose, and to drive it up by presenting the same odors to the vulva. He, the same as Plato, gave it the use of feet to make speedy journeys, taking a morning's out, go up in the throat or the lungs; according to them, had muscular power to do almost anything, except handle Indian clubs and like trivialities.

Galen, that genius of common sense, taught that hysteria was caused by the suppression of the menses or a retention of the semen.

Piso, or Le Pois, gave hysteria a cerebral origin. Whyte approached the subject first in its modern scientific spirit.

Brequet, in 1859, placed it in position to be studied in the broad scientific method which characterizes it at present.

It is asserted that Brequet rendered the school of Charcot possible. It was this school of Charcot, presided over by a rare genius, which has rendered it possible to take in the broad and ever-interesting phases of this wonderful, amazing, and far-reaching enigma of medicine. To-day, a modern definition of hysteria would read that it is a psycho-neurosis—not a protean affection; but a well-rounded, morbid entity; never at any time a conglomerate trouble, but a profound and genuine disease of the cerebral centers. The physical symptoms are the most conspicuous, tending to disguise the mental phenomena and to simulate superficially the effects of various organic diseases.

Heredity is the almost universal cause of hysteria—the one great predisposing cause, since all others are only exciting. Colin says "the leading characteristics of the hysterical is the disproportionate impressionability of their psychic centers. They are, above all, impressionable." Gilles de La Tourette says that, in addition to this disproportionate impressionability, a second peculiarity, equally as remarkable, important and exaggerated, is the exceeding ease with which they can be made to yield to suggestion. Now, suggestion has no limit; it may occupy the entire world, animate and inanimate. Suggestion is that which is introduced indirectly to the thoughts; to cause to be thought of by the agency of other objects; an intimation, an insinuation, a hint; to seduce, to tempt; information without oath or with it. In the vast field of psychic realms, none occupy, either in the normal world or the hysterical realm, deeper, more profound and far-reaching power than suggestion, which accentuates attention, the beginning element of brain use and waste. The hysterical have, in addition to an excessive emotionalism and unusual help in susceptibility to suggestion, a love of self enormously exaggerated. As Nordan says: "The hysterical person's own 'I' towers up before his inner vision and so completely fills his mental horizon that it conceals the whole of the remaining universe." Subject to suggestion, a passion for imitation, an hysteric desires to be as important to his fellow-men as he is to himself. Sense impression dulled or exaggerated. Red enthuses, exhilarates; violet enervates; indifferent to yellow and blue, owing to a hysterical, insensitive retina. The hysterical believe everything suggested to them with sufficient impressionableness. He believes. Consciousness in them, often acquires a distorted and blurred view; hence, they overflow in false judgments, false qualities, and false views. Attention, life's prod to a brain, oft makes them weak and inattentive, then to overflow with excessive excitability. Imaginative, imitative, impressionable, a slave to suggestion, an abnormality of egoism, a mystic dreamer or a frenzied, deluded actor, and a martyr to forceful surroundings. An ill-balanced, deluded, impressionable psychic anomaly, hysteria may be not inaptly termed as the mob of the emotions which commits riot upon an emotional soul—psychic drunkenness which appears to exaggerate both vices and virtues.

Their inordinate emotions and sensibilities use up the very force that was given for use and happiness. Besides, hysteria gives a perfect view of man—makes plain within him the saint, villain, or fool. Alter Pope a little, and thus it reads:

Search for the ruling passion in Hysteria:
There alone are the cunning known, the wild constant,
The fool consistent, and the false sincere.

Again:

Hysteria, be thou what thou will,
Ruling Hysteria conquers reason still.

The writer has been interested in taking the general term of passion, striving to find whether the poet and others have unconsciously described many of the symptoms of hysteria. Thus, view these lines by Mrs. Landon:

"What is Genius but deep feeling
Weakened by passion to revealing?
And what is feeling but to be
Alive to every misery?
While the heart, too fond, too weak,
Lies open for the vulture's beak."

Change "Genius," "feeling," "heart," and you have this:

What is Hysteria but deep feeling
Weakened by passion to revealing?
And what is Hysteria but to be
Alive to every misery?
While the brain, too fond, too weak,
Lies open for the vulture's beak.

Again:

In Hysteria's brain feeling overflows and thrills,
Makes suggestion glow to stifle reason still.

Again, as in Higgins, "hysteria" is put in place of "passion," and reads:

When headstrong Hysteria gets the reins of reason,
The force of nature, like too strong a gale,
For want of ballast, oversets the vessel.

Or, as in Scott, for "passion" put "hysteria," and you have this:

His soul, like bark with rudder lost,
On Hysteria's changeful tide was tossed;
Nor vice nor virtue had the power
Beyond the suggestion of the hour.

The disproportionate impressionability of the hysterical is a constant and easy arouser of the emotions, and were it not for the fact of its ever-

changing moods, this turning back of the emotions upon the brain would lead to madness. It is only the fixed element of thought and emotions which constitutes the basis of madness. The changing phases of hysteria constitute it a momentary madness. The hysterical is, indeed, almost antithetical in character. He takes notice as meaning commendation, and precise ceremony as profound respect for him alone. His vanity is ridiculous; his pride contemptible; his words are so filled with exaggerated impressions as to make him, in the eyes of the unversed, as being a perfect prevaricator, a bold, willful falsifier. The foundation of all his trouble is grounded upon an inherited defect, where fancy, imagination, morbid mobility, extraordinary emotionalism, excessive excitability of imagination retints and conveys to his consciousness a maze of queer, ridiculous and senseless ideas. He is not a liar, but a germ-made romancer, a psychic, God-made electric battery, which plays tuneful discords to the forceful touch of suggestion.

Perchance hysteria may be the solution of the most famous of all enigmas, referred to as the "Ælia Lælia Crispis," an inscription preserved at Bologna, which has puzzled the wisest heads and has finally been given up as insoluble:

"Ælia Lelia Crispis."

"Nec vir, nec mulier, nec undrogyna;
Nec puella, nec juvenis, nec anus;
Nec merstrin, nec pudica;
Sed omnia;
Inflata neque famo, nec ferro, neque veneno,
Sed omnibus;
Nec cælo, nec aquis, nec terris,
Sed ubique jacet."

Which, when rendered, does not inaptly picture hysteria:

"Neither man, nor woman, nor hermaphrodite;
Neither girl, nor boy, nor old woman;
Neither harlot, nor virgin;
But all of these;
Destroyed neither by hunger, nor sword, nor poison,
But by all of them;
Lies neither in heaven, nor in the water, nor in the ground,
But everywhere."

Even as a surgeon, minding off to cut
Some cureless limb, before in use he put
His violent engines on the vicious member,
Brougeth his patient in a senseless slumber,
And grief less then (guided by use and art),
To save the whole, saws off the infected part.

—Du Barts.

CLINICAL LECTURES.

I.

MEDICAL CLINIC.[1]

By Francis Delafield, M. D., of New York.

Professor of Practice of Medicine, College of Physicians and Surgeons; Attending Physician Roosevelt Hospital; Consulting Physician Bellevue Hospital, New York City.

Case 1.—Subacute Miliary Tuberculosis.—The first patient that I will show you is a woman, twenty-three years of age, who was admitted to the hospital on the eighth day of December. So far as we could make out, she has had ordinary health, except for a little cough, which lasted for two years. There are no night-sweats, and nothing at all distinctive about her history until the 22d of November, when, without exposure, she was suddenly taken with a severe pain in the back. She went to bed. Two days later she had a cough with a profuse muco-purulent expectoration. Since then she has been sick with a good deal of cough, muco-purulent expectoration, troublesome dyspnœa, dull pain in the chest, which is increased by cough and inspiration, and night-sweats. When she came in her temperature was 104°, her pulse 132, and her breathing 42. She looked like a very sick woman. Her tongue was dry and coated. There was found subcrepitant rales behind over the left lung; the air entering the alveoli heard over the right lung behind showed there was something in the way of a subcrepitant rale; the breathing was distinctly feeble, and the air was not entering as well as on the left. There was also comparative dullness. In front there was no change. The subcrepitant rales were distinctly heard. The liver, heart and kidneys were found to be normal. That was the history she gave upon entering. The sputum was examined for bacilli and none found. If you will look at the temperature chart taken since she came in you will see that she has been going on having high temperatures, running between 101° and 105° and over, being higher in the afternoon and lower in the morning. With these high temperatures the breathing has been about 48 and the pulse between 108 and 148. So she not only has been having a high temperature, but also rapid pulse and breathing. To-day is the twenty-first day of her disease, so far as we can make out. The main symptoms have been constipation, febrile movement, cough with profuse expectoration, rapid pulse and breathing. The physical signs show the subcrepitant rales over a large part of both lungs; the subcrepitant rales have been large showing a general bronchitis over both lungs, the bronchitis extending down to the smaller tubes. Over the left lung there is no pain. Over the lower part of the right lung the percussion sound is relatively dull and the breathing is diminished. Now, what do you believe is the condition of the lung—what disease is it? It is evident that she has a general bronchitis. Now, of course, in addition to that she may have an acute miliary tuberculosis; if that is so, in what part of the lung would you put it? On the right side and probably in the lower lobe of the right lung. That I imagine to be the condition here. This patient is an example of a severe form

[1] Held December 12, 1898, at Roosevelt Hospital.

of acute miliary tuberculosis involving part of the right lung. Now, with this there is a high temperature, which belongs to these marked cases, running up to 104° and 105° in the afternoon, and the marked prostration. In other words, there are evidences of marked systemic poisoning and rapid development of tubercular infection of the right lung. This is a case of acute miliary tuberculosis. Now, in this girl the conditions are not absolutely simple. She might have, in addition, a general bronchitis involving not merely the right lung where the tubercles are, but also the left lung where there is no reason to believe there are any tubercles. Still further than that, the marked change in breathing, and the dullness over the right lower lung, makes one believe that there is a diffuse pneumonia making a moderate amount of consolidation; that is, an exudative pneumonia. Whether, in this girl, there previously has been a tubercular pneumonia at one apex, with symptoms of influenza, we cannot be certain. From the character of the general bronchitis the influenza was probably the exciting cause; that is, there was an old localized tuberculosis with the poisoning of influenza, and a general bronchitis at the same time developed an inflammation of the lung. This patient, then, is not to be sent away, but she should be kept in bed and treated in bed as a patient suffering from inflammation. She is kept in bed, on a fluid diet, and constantly inhaling the vapor of creasote. This constitutes the treatment.

CASE 2.—LOBAR PNEUMONIA.—The next case I wish to show you is a woman, sixty-five years of age, who was admitted to the hospital November 27th. For several years she has had dyspnœa on exertion. She has had ordinary health until the 21st of November, when she was suddenly taken with a chill, vomiting, pain in the left shoulder, back and head. She has been sick in bed ever since. About the third day she began to have cough with a little expectoration. She has had no appetite and has been delirious since the 5th of November. She came into the hospital with a temperature of 102.6°, pulse of 112, and her breathing 36. Her tongue was dry and remained dry. The pulse was fair. Her breathing was shallow. The specific gravity of her urine was 1022, and contained no albumin and a few hyaline casts. Over the whole right chest behind down to the angle of the scapula there was dullness of percussion and bronchial voice and breathing, with fine crepitant rales; there was also crepitant rales at both bases. The bronchial voice and breathing was found in the axilla, high up. Over the right chest there was dullness and fine crepitant rales. In other words, the physical signs were those of a lobar pneumonia, involving the upper part of the right lung, and the history given was the ordinary one of the invasion of such a case. She came in with a dry tongue, with a rather bad-looking face, alternating delirium and stupor. Her whole appearance was that indicating not only a lobar pneumonia, but also the poisoning of a lobar pneumonia. She looked as if it was not a regular case, but one showing constitutional poisoning. There were more evidences of a bronchitis on the left side; the physical signs of consolidation of the right upper lung continued. Now, we can see the temperature running from the 7th to the 15th day, and it is a fairly high temperature; it has not fallen to normal. On the 15th day it was 103°; then it went on to the 16th and 17th, and has since been lower. From the 17th to the 22d it has been running between 99.5° and 101°, but

yet the woman is not convalescent, and she is distinctly not better. She still has a dry tongue and has constipation, is delirious and does not take her food well. The consolidation of the right lobe still continues. This history is different from the ordinary histories of lobar pneumonia; she is behaving like a patient with typhoid fever rather than with lobar pneumonia. Still, I imagine that the lobar pneumonia is the only thing she has, but it is a particularly infectious form of it. The pneumococcus sometimes behaves in that way, the infection being entirely out of proportion to the extent of the lung involved. Three days ago the woman looked better—as if beginning to get out of her condition of poisoning. Although the lung was still consolidated, I imagined that she was beginning to emerge from her poisoning; yet she has not. She is not as constipated as she was. She has the typhoid face; that is, the venous face. The circulation is now better. She still has a temperature of 101°; her tongue is dry and she cannot take food properly, and the lung is not yet resolving. Here is a long, infectious case of lobar pneumonia. The treatment of these cases is comparatively unsatisfactory; the only good treatment I believe to be with antitoxin, and we have not yet gotten it. We must do the best we can with good nursing. I use the following mixture:

℞ Iodide of potassium ..... gr. v
Ext. digitalis fluid ..... m ij
Ext. convallaria fluid ..... m xv
M. Sig.—Four times a day.

The heart's action is fairly good. The pulse, on some days, is as low as 84. The breathing is not now very rapid. The pulse at first was 112; it now runs from 116 to 120. So that although she is still holding her own, yet she is still in a somewhat typhoid condition. This woman looked entirely different ten days ago; we did not know whether she would die or not. Now she is somewhat better and I believe will continue to improve.

CASE 3.—PLEURITIS WITH EFFUSION.—This boy is fifteen years of age. On the 1st of December he was suddenly taken with a chill and prostration. He came into the hospital on the 4th of December. On the first day there was a sharp pain in the upper part of the right chest, increased by cough and deep respiration. He had a muco-purulent expectoration and, at times, the expectoration was blood-stained. Since he has been suffering from the cough and the prostration. He came in with a temperature above 103°; pulse, 112; and breathing, 28. The urine had a specific gravity of 1024; it contained no albumin. He came in with a temperature nearly 104°, and it dropped rapidly, and he has had a normal temperature for several days. He came in on the 4th day of his sickness; on the 5th day cough, and on the following day, the 6th, the temperature was nearly normal; and now, the 12th day, it remains normal. That would be the ordinary history of an influenza ending in recovery; but that was not all. When he came in he had flatness on percussion on the right side, from the clavicle extending downward; the flatness was well marked; there was absence of voice and breathing—and still further than that, one could see pulsation about the third intercostal space; this pulsation was distinct on the right side. In other words, the physical signs of a sacculated pleurisy in the upper part of the right chest was present, which pul-

sation was communicated by the heart's action through the fluid. He came in with a high temperature, and we could not tell whether it was a sacculated pleurisy or a sacculated empyema. But the rapid fall in the temperature and the improvement of the patient would make it probable that it was a pleurisy rather than an empyema. The physical signs have changed somewhat since he came in. Three or four days after coming in the flatness was less marked; still, the flatness was above the clavicle but diminished below, and it showed the fluid disappearing. But now there is marked flatness all the way down to where we strike the liver dullness. In the axilla it changes. The flatness remains in the upper part of the right chest. There is no vocal fremitus there; breathing cannot be heard over the area of flatness. The voice is absent. So that shows the fluid has been, apparently, diminishing in quantity at first and then increasing in quantity, although the boy's general condition is very good. I have been waiting because the boy has been doing so well before aspirating; I never aspirate in front, but place the needle in the back; there I do not hesitate, but I am not fond of putting in the needle in front; and, too, I am always willing to wait and see if the patient will get along without this procedure. Yet, in the boy, we will have to aspirate in the third space. The boy is eating well and doing well. At first the pulsation was visible but now it can only be felt. It is being absorbed. Although the physical signs are not now great, yet there is flatness on percussion. I cannot get voice or vocal fremitus.

CASE 4.—PNEUMO-THORAX.—This man came into the hospital on the 8th of December. He has had a cough lasting one week or two every September; at other times he has not been subject to cough. Last September the cough was worse than usual, but it ceased and he had no more cough. There was no dyspnœa or loss of strength; there was no renal symptoms. His appetite was good and his pulse regular.

There was the history of a man who, except for having a cough in September, was apparently in ordinary health until the 30th of November. Then, while sitting, he was suddenly taken with severe dyspnœa and felt, as he expressed it, "as if his spine was squeezed in a vise." This attack of pulmonary dyspnœa came on while he was quiet at the table. The pain continued but he could not localize the pain very well. The pain and dyspnœa continued severe during the afternoon of the next day, and then the pain and then the dyspnœa began to diminish. About December 3d there was no dyspnœa except on exertion. This has gradually diminished since. Since December 6th he has had a little dry cough without expectoration and no pain. There was no loss of strength or flesh. The appetite is good and the pulse regular. The chief complaint is the dyspnœa on exertion. When he came in his nutrition was good; the tongue moist and coated; the temperature was 98°; the pulse only 60, and the breathing 18. Remember, he came in on the 8th of December, after having had an attack of pain and dyspnœa on the 30th of November. His urine was normal. He did not feel very sick. The history and general condition of this patient would hardly make you think what the actual condition of this man is. You see, this man is not at all badly nourished. But you can see the apex of the heart is much further to the left than it should be; it is way over to the left. Then, on mensuration, the right side of the chest measures one

inch more than the left side. Upon full inspiration there is not much difference between the two sides of the chest. Percussion shows no difference in the resonance between the two sides in front. There is a little difference in the quality of the percussion note, the right side not being so distinctly pulmonary as the left side is. Auscultation shows amphoric breathing over the whole of the right chest.

Here, then, we find the physical signs show that the right chest measures one inch more than the left; that when the patient takes a deep inspiration both sides of the chest move; that vocal fremitus is present on both sides; that pulmonary resonance is present on both sides, but the quality is slightly different; the heart is tipped over to the left; that amphoric breathing is present over the right chest. Now, what has he?

This man has a pneumo-thorax, which is behaving differently from most cases. The time he had a sudden attack of dyspnœa was the time when a little cheesy nodule under the pulmonary pleura in the right lung ruptured, and then the air escaped from the lung into the right pleural cavity, which was accompanied by the pain and dyspnœa. The right pleural cavity has been distended with air from that time on, and the heart has been pushed over to the left side. There has been no accumulation of fluid. The reason why the man has been doing so well, with so little disturbance of the breathing or of the pulse-rate, with his nutrition and general condition so good after ten days, I suppose there must be the following reasons to explain it:

First.—The ordinary tubercular lesion on the right lung is really a small lesion, indeed, because it was not accompanied by systemic infection. There was no febrile movement at all. That means there was a small tuberculosis without systemic infection.

Second.—That at the end of ten days no pleurisy had been established. Of course, one of the principal dangers of pneumo-thorax following rupture of tubercular nodule and entrance into the pleura of this material is the irritation of the pleura and the subsequent setting up of a pleurisy with effusion. In this man there was no such irritation I suppose because the man was in such an excellent condition. One could hardly believe that a man could have such a serious lesion as this man has and yet do so well. There is no special thing to do; the air must become absorbed and that opening must heal up. So long as he has not developed a pleurisy his chances of recovery are good; he ought to get well.

To Apply Dressings to the Knee and Elbow.—Unna aplies a layer of zinc oxid glue to the extensor muscles, above and below the articulation, and then paints a strip five centimeters wide around the limb, leaving the front of the joint untouched. The desired salve or plaster is then applied to the joint, covered with an impermeable cloth and then with a layer of the zinc glue. A long strip of gauze is then wound around the whole in a figure 8, crossing on the point of the elbow or knee, while the inner bend is left exposed. The outer layer of gauze is then painted with glue and a layer of cotton applied. This dressing remains in place, does not interfere with the movements of the joint, and can be left for several days.—*Semaine Méd.*, December 7th.

II.

MEDICAL CLINIC ON DISEASES OF CHILDREN.[1]

By AUGUSTUS CAILLÉ, M. D., of New York.

Professor of Diseases of Children; Attending Physician to the Babies' Wards Post-Graduate Hospital; Visiting Physician to the German Hospital; Consulting Physician, Isabella Home and Hospital.

CASE 1.—PUSTULAR ECZEMA.—We have some very interesting material to show you this morning. Some of you have seen this case before. She has a pustular eczema. Remember, I told you to look for a nasal discharge; and it will be usually found in cases where the situation of the lesions is as seen in this subject. The ordinary method of treating these cases with plasters and salves is an unfortunate one. If you wish to get rid of it altogether, you should scrape off the scabs and then cauterize the bleeding points with nitrate of silver. The plasters and salves clog over the eczema and do no good; the glands become infected, and the patient becomes worse than she was before treatment. The proper way to treat these cases is to simply scrape away the scabs rather forcibly, as I am now doing. Then the bleeding points should be cauterized with a solution of nitrate of silver, ten grains to the ounce, and then the parts compressed for a short time until the hemorrhage stops. Over this, then, is placed zinc ointment to protect the parts. In about a week the eczema should heal over promptly.

CASE 2.—JAUNDICE NEONATORUM.—Here is a little baby who, if held in a good light, would be found to have a yellow color. This is an ordinary case of jaundice neonatorum. This child is thirteen days old, and there is nothing wrong except this yellow color. The pathology of this condition has not been cleared up, and there is no treatment so long as there is no fever. The treatment is really immaterial, for these cases usually get well, no matter what you may do. These cases are quite common; but, remember, there is no treatment to be directed to it if the case be not one of infection.

CASE 3.—ADENITIS FOLLOWING SCARLET FEVER.—Here is a little fellow with an adenitis on the right side of the neck, following scarlet fever. Now, you can treat these cases by running in a dressing forceps, after incising into the tumor, and so break up the glands, and in that way get rid of the trouble. But the surgeons here prefer to remove the glands entirely, so this child will be placed in the ward and that operation will probably be done.

CASE 4.—CHANCRE OF THE LIP.—This is a very interesting case and one that is extremely rare, and I want you all to come down and see this case closely. I call your attention to this lip, which, you see, is very markedly indurated, with enlarged glands on the same side as the lesion below the angle of the jaw. There is no adenitis on the opposite side. This is a chancre of the lip, and I caution you gentlemen to be careful and wash your hands after handling it. The upper lip is infiltrated and hard, as, also, is the submaxillary gland. There is a complete history of infection from some one in the family. This is a hard syphilitic chancre of the upper lip, with adenitis; the history of syphilis is very clear in this case.

[1] Held at the Post-Graduate Medical School and Hospital, on December 20th, 1898.

This child's parents have a boarder who is syphilitic and who has been kissing the child. This child should at once be placed upon mercury by the mouth, and, at the same time, by inunctions, in order to get him under the influence of the drug as soon as possible. The prognosis is favorable in children of that age. This is really a most unfortunate case—getting syphilis in that way. The treatment should be kept up for a year and then stopped for a few months, when it should be again resumed. I have seen the same person attacked twice in a period of twenty years. The man had syphilis with all the secondary symptoms, and was under treatment for seven years; after a few years he again was stricken with this trouble, with all the secondary lesions of the first attack. I believe a great many have seen this same feature.

CASE 5.—ACUTE MENINGITIS.—I have here to show you a case of pneumonia and also an acute meningitis—evidently a grippe meningitis. I believe Dr. Chapen has shown you the case before. The case was brought in with a normal temperature, and it suddenly rose to 104.5°, with accompanying symptoms of acute meningitis. My colleagues here will find in the babies' wards a tubercular meningitis which is moribund, and which has been watched for a long time. Whenever a case of meningitis is tubercular, we learn that fact from lumbar puncture and microscopic examination. By lumbar puncture you get nearer the truth. Although there is no real indication to do a lumbar puncture here, I think I will do it, to demonstrate the method. This procedure is calling forth a considerable amount of discussion; but its value has about been settled—not as a therapeutic, but as a diagnostic measure. This child is still in the excitable stage, but I will attempt to do it. The landmarks used in performing this operation are about as follows: I want to go between the fourth and fifth lumbar vertebræ. The position of the child should be the sitting posture, with the body bent forward and the spine so curved that the spaces between the vertebræ will be increased to afford greater facility in getting in. A good plan is to draw a straight line across from one iliac crest to the other, to locate where you wish to enter. Then place the finger-tips upon the spinous process above and upon the spinous process below. With the finger-nail we then make a mark, which will be the guide to the point of entrance of the needle of syringe. With the needle in the proper direction I now endeavor to get into the space, taking plenty of time. Now I believe I am in the space, and please notice that, as I withdraw the piston of the needle, a fluid follows the barrel of the syringe. After the removal of the needle, the cerebro-spinal fluid can be noticed oozing out through the puncture. Take care that the child is properly held, or the needle may be broken off. If you go in too far, you may puncture the plexus of veins, which will give you troublesome hemorrhage to deal with. One should first practice on a cadaver, and then it can be done quite readily. Now, what does puncture do? It gives you a fluid which can be examined and possibly show the presence of the streptococcus, or the staphylococcus, or the pneumococcus, or you may find a sterile fluid; anyway, this procedure will reduce the pressure by removing part of the fluid. Two or three ounces can be removed in this way. This that I have removed appears to be a little turbid; not much so. According to my personal experience, the cerebro-spinal fluid that becomes clear is not likely to be one of the vari-

eties of meningitis which will produce pus. We will examine this fluid and report to you later what we find.

As regards the treatment of this child—of course, there is no specific treatment in this stage. Assuming that the salicylates have some specific action upon some forms of microbes that produce rheumatic fever, it would not be out of the way to give salicylates. Nor would it be out of the way to give a dose of quinine. If there is any malaria in this meningitis, one should give a specific dose of quinine. I believe quinine should be given, anyway, to be followed later by the salicylates. Otherwise, treat the case symptomatically.

CASE 6.—PNEUMONIA.—This child is just recovering from a pneumonia, and now there is some dullness, bronchial breathing, and the typical signs of a pneumonia. This shows well the tubular breathing and other signs, and I wish you gentlemen to come down and listen to this chest. This little one is in complete defervescence. A grippe pneumonia in children is rather distinct. As a rule, there is some diarrhœa, with sudden onset, and intense redness of the pharynx. This case is quite characteristic.

In regard to the treatment of grippe cases there is no specific yet known. When taken in the very beginning, quinine and phenacetine, three grains of each in children and eight grains of each in adults, with stimulation, is given; under this medication they usually get along nicely. The treatment of pneumonia accompanying grippe is no different from the treatment of any other pneumonia. So soon as the grippe bacillus is discovered, and we can get the antitoxin, the treatment will then be very simple; but, with our present knowledge of the disease, the treatment must be symptomatic. In grippe pneumonia do not hesitate to place the patient in the wet-pack so long as the circulation is good; use the warm bath gradually cooled down to eighty degrees; before using this method, it would be wise to see if the child's feet are warm.

CASE 7.—PHIMOSIS.—This child has a phimosis. Any colleague here who wishes to perform the operation of circumcision can come down and do it, and we will assist him. If this was a dispensary case, to be sent away directly after the operation, it would be a good plan to use black thread in sewing, because it is easy to find it after a few days. In dispensary work also use iodoform or bismuth ointment, applying the ointment to the parts every time the child urinates. In dispensary practice you cannot make an antiseptic dressing as you could in private practice. If catgut is used, it becomes absorbed and does not necessitate removal; but I do not like the knots that must be used.

Why do I use ether instead of chloroform in this child? On account of the prejudice. If chloroform be given, and anything should happen and the child should die, the coroner's jury would make it very unpleasant for the physician; whereas, if ether be given, it would probably be all right.

INTRAOCULAR HEMORRHAGE.[1]

By J. H. THOMPSON, M. D., Kansas City, Mo.

HE term intraocular hemorrhage means, in this communication, all forms of spontaneous hemorrhage which involve the inner tunics of the eyeball or break through the retina into the vitreous chamber. Of course, under this heading should come hemorrhagic glaucoma; but since that would alone comprise a thesis, I have determined to avoid the glaucomas and limit my remarks to retinal and choroidal bleeding.

Certainly, there are very few who can doubt the importance of this subject, for scarcely a week passes without some such case presenting itself; and, if I am to judge from my own experience, without some degree of perplexity.

The diagnosis of intraocular hemorrhage is usually easy, but the etiology often difficult to determine.

The uncertainty of the cause has a marked bearing on the prognosis; and, since hemorrhage into the retina is frequently the first evidence of a mortal disease, its study is of paramount interest.

In passing, let me remark that in this branch of ophthalmology the physician and oculist must go hand in hand; for in the majority of cases the lesions in the eye are symptoms of grave constitutionl disorders, which cannot be relieved by glasses or partial tenotomies. They call for considerable diagnostic skill on the part of the doctor, and imperatively demand that he should know how to examine the urine, test the arterial tension, and determine the condition of the heart. Another circumstance which should make this paper of interest is the subject is now being discussed by the entire ophthalmic world; started by Abadie in the Paris Ophthalmological Society, and participated in by such men as Panas, Fuchs and Ammon of Zurich, to whom I am indebted for some valuable ideas.

SENILE HEMORRHAGE.—It is not at all uncommon to find in the retina or vitreous of old persons evidences of recent or remote hemorrhage. They may be suspicious opacities floating in the vitreous, but usually there are blood spots disseminated over the retina or arranged around or within the macula. The extravasations may be along the arterial branches, which are evidently atheromatous; often they will be in places free of visible vessels.

In some instances I have observed quite large and well-defined bleedings around the macula, which were evidently under the retina, for they caused a baggy detachment of the retina. Sometimes the lesion is single; then, again, two or more large extravasations will be arranged around the posterior pole. Usually there are signs of diffused retinitis, viz., congested and tortuous veins, blurring of the disk, and large retinal trunks, with

[1] Read before the St. Louis Academy of Medical and Surgical Sciences, November 24, 1898.

patches of exudation and degeneration. But I have seen several cases of central hemorrhage without retinitis. It is not readily demonstrable at all times where the hemorrhage arises. Often the streaked character of the extravasation shows that it is in the retina itself; then, again, the blood clot will distinctly cover a vessel, showing that it lies adjoining the vitreous. I am certain that I have seen cases where the blood was between the retina and the vitreous body, detaching it as the serum may do in extreme malignant myopia.

A large clot may be between the retina and choroid, so that it is presumptive that a choroidal vessel has given way. I saw such a case some years ago. There was a well-defined detachment of the retina at the macula. It was round, about four dioptres deep and about two-thirds the diameter of the disk. It was filled with fluid—the upper part serum, the lower part blood; between the two was a well-defined horizontal line, showing where the red reflex ended and the colorless began.

Such are the usual forms at the fundus. At the equator the vitreous seems to have less resistance, so a hemorrhage—which in other parts would be limited to the locality of the ruptured vessel—will then, probably, break into the posterior chamber and form a large clot, or force its way between the vitreous body and suspensory ligament to reach the posterior surface of the lens. As said before, there may or may not be signs of retinitis. According to my observations, if there are multiple hemorrhages, or if the clots are large, there is always irritation in the retina. So I am inclined to think that the presence of blood in the retina is itself a cause for retinitis; and since those hemorrhages in the aged are nearly always associated with atheromatous vessels, and such subjects commonly have more or less albumin in the urine, it behooves one to exercise the greatest care that he does not mistake the condition for Bright's retina.

I now wish to leave the eye and make some remarks preparatory to the subject of albuminuric retinitis. I do not know how it has been with you but I have been laboring under many errors regarding albuminuria. We have known for a long time that there are cases of transient albumin in the urine in persons without disease of the kidneys, and that this is especially true of old people; many times dependent upon unknown causes, often directly attributable to gout, arterial sclerosis and heart disease. I had no idea that the condition was so common, and until my errors prompted me to especially study the subject, I was shamefully ignorant. Although albumin in the urine is strong presumptive evidence of disease of the kidneys, the condition may exist for a long time yet the urinary organs be perfectly healthy. Therefore, it is unwise to make the diagnosis of Bright's disease solely because of the albuminuria. In doubtful cases it should not be made until the urine is collected for several days and measured; its specific gravity is continually below 1018, together with granular and hyaline casts and a deficient quantity of urea. On the other hand, the kidneys may be markedly degenerated, with urine of low specific gravity and small quantity, yet, at times, containing no albumin. I say at times advisedly, for I have never yet seen a case of disease of the kidney, whether cirrhosis or chronic parenchymatous nephritis, that there was not found at some time albumin in the urine. The error that prompted my investigation in this line was regarding an old gentleman, fifty-eight years, a

strong, healthy farmer. He consulted me for partial blindness. There was marked neuritis, multiple hemorrhages into the retina, and a large clot free in the vitreous. The urine was albuminous. Therefore, I made the diagnosis of retinitis albuminurica, and exepected him to die within twelve months. It is now nearly three years since I first saw him, and although he is totally blind in one eye, and nearly blind in the other, yet he is a picture of health, and his urine still contains albumin. I do not mean to say that these cases were not Bright's disease; but I do believe that often retinitis hemorrhagica is dependent upon causes irrespective of the kidneys. When the blood leaves an artery, it does so from one of two causes: either the vessel has ruptured or the blood itself is diseased. Nothing can so certainly lead to friability of the vessel walls as atheroma and the diseases induced by syphilis.

Therefore, in the class of cases like the one I have reported, it is well to consider these causes and differentitate between them and renal disease.

Multiple small hemorrhages into the retina, with or without retinitis, are very frequent in old persons with sclerosed arteries and diseased heart, without disease of the kidneys, and because there may be traces of albumin in the urine, they are not necessarily of deadly import.

We have not the time to consider retinal hemorrhage dependent upon scorbutus, syphilis, lead poisoning, diabetes, septicæmia, etc. I wish to call your attention particularly to the intraocular hemorrhage of adolescence. As the name implies, this form of hemorrhage occurs most frequently between the ages of eighteen and thirty, and more often in males than females. The extravasation may happen at any part of the retina, around the macula, or at the equator. The lesion may be a streaked blood stain in the retina, or a clot between the retina and choroid.

Unfortunately, there is usually an enormous outpouring of blood behind the ciliary body, which either breaks through into the vitreous, or forces its way between that body and the suspensory ligament to reach to or extend beyond the lens. Although we have reason to think that a single large vessel has given way, I have sometimes found, in cases of great hemorrhage, where it has been possible to see the extreme edge of the retina, that there were large, irregular blood-red patches, unstreaked and mormorated, resembling blood stains, and suggesting a condition called diapedesis. This fact is extremely interesting, for it throws some light on the cause.

One would expect that in excessive hemorrhage the diagnosis would be easy. With the pupil widely dilated the blood cannot be distinctly seen, even when the clot lies immediately behind the lens. By focal illumination it is possible to get a faint bloody reflex; but when we remember that such reflexes often depend upon the source and character of the illumination, it is hard to determine positively that what is seen is blood. This uncertainty only exists in the beginning, for as soon as absorption disintegrates the clot the light will pour through, when the nature of the lesion will be revealed. When a hemorrhage lies under the conjunctiva, or in the anterior chamber, the hæmatin soon stains the iris. But however large a bleeding may be in the vitreous, the iris is never stained, showing that the suspensory ligament is impervious to fluids. If it were

otherwise, the diagnosis might be easier. I do not mean to hint that we cannot determine that the black object behind the pupil is blood, but it is difficult, as is often the case in complete detachment of the retina, where that membrane hugs the lens. Such experience, I take it, we have all had.

The relation of the effused blood to the vitreous is important, for very soon the jelly mass liquefies, which subjects the eye to future changes, detachment of the retina, posterior polar cataract, etc. I must admit that I have no fixed idea of the cause of these hemorrhages in young people. I do not believe they are always from the retina, but often from the vessels of the choroid and from a constitutional cause. There is a peculiarity I have long noticed, which I find is mentioned by the latest authorities. It is, these subjects usually belong to the laboring class. All my patients have been young farmers who have been attacked shortly after severe labor in the harvest field. This fact, associated with the symptoms of blood diapedesis, makes it strongly probable that the cause is in the blood itself; so I think that such hemorrhages are at the time scattered throughout the body, but observable in the eye because a lesion there is strongly symptomatic which would in other places be unnoticed.

This disease is grave, for there is great probability that repeated bleedings will finally destroy the eye.

The treatment should be directed both to absorb the blood and to remove the supposed cause.

I am inclined to think that nothing should be given to hasten the absorption of the blood clot—that it should be left to nature and rest. The only medicine I know which could be of any service is the iodide of potash, but that is contra-indicated because of its harmful influence on the blood. Pilocarpin may be of service, and I think can be used with safety.

Usually, without any therapeutic help, the blood will be absorbed; but the danger is in a fresh hemorrhage. To prevent this is our paramount duty. My plan is absolute rest, gentle purgative, and the administration of the sulphate of quinine. Abadie highly recommends sulphuric acid, given in the form of lemonade.

For the retinal hemorrhage of old people with arterial disease, whether it be from gout, Bright's, or simple sclerosis, when there is an elevation of the arterial tension, chloral, with or without opium, is a remedy.

There is no doubt that the eye is subject to vicarious hemorrhage, suppressed menstruation and suppressed pile bleeding being the cause.

Is it possible, is it probable, that the intraocular hemorrhage of adolescence is in some way related to functional disturbance of the reproductive organs?

This is merely a supposition which may suggest to us, as Shakespeare said, that there are some things in the philosophy of nature little dreamt of.

THE GRIPPE EAR.

By FAYETTE C. EWING, M. D., of St. Louis,

Fellow of the British Rhinological, Laryngological and Otological Association.

OF THE many complications of grippe, none are commoner than the "grippe ear." The average practitioner is wont to consider the so-called abscess in the ear from influenza as like that from any other cause. But the manifestations of acute suppurative otitis media as a result of grippe differ in essential and important particulars from the condition that arises from naso-pharyngeal congestion. The "grippe ear" is likely to present a hemorrhagic exudation before the tympanic membrane gives way. Not infrequently, with the rupture there is a discharge of blood—in other words, a true hemorrhagic otitis. A characteristic of the grippe ear is persistence of pain after the rupture. In ordinary otitis such a symptom is of very serious import, indicating insufficient drainage and deep inflammation with tension. Politzer, Gruber and Truckenbrad experienced mastoid complications oftener than in simple inflammatory otitis; but this has not been the observation of many other noted observers.

The otitis from influenza is certainly more painful than that of the simple variety, but the consensus of opinion is that it is not less likely, with suitable treatment, to end in perfect recovery. The pain behind the ear in true mastoid disease is apt to be directly over the process, or at its base, while that from grippe otitis, without deep origin, is generally behind the process—at the junction of the occipital and temporal bones. Many such cases subside under vigorous treatment, which would indicate a neuralgic character.

The treatment does not differ materially from the simple inflammatory affection. In all cases of acute otitis, inflation, through a certain stage, to prevent anchylosis and adherence of the flaps to the side of the tympanum, as well as to keep open the eustachian tube, is most important. Just how long this inflation should be kept up can be determined only by a study of each individual case. If the physician does not feel himself competent to arrive at a correct conclusion, he should consult some one who is. Certainly, any deprivation of hearing cannot be lightly considered. Treatment that makes for cleanliness alone is only half the necessary therapy; but inflation kept up too long may result in harm from interference with the healing together of the flaps.

AFTER-EFFECTS OF INFLUENZA.

By ROBERT F. AMYX, M. D., St. Louis, Missouri.

THE epidemic of influenza which is at present in many of the larger cities of this country seems to have brought with it many conditions that were not given much importance, or were not recognized during former visits of this disease; this may be said of the conditions arising late during the convalescent period.

The attention of the medical profession was almost wholly given to the symptoms and complications during the acute stage and early part of convalescence; little consideration was given to symptoms arising at a later period until they had reached a degree that became alarming to the patient. At present the profession are more alert to check as well as to detect any new phase of influenza, whether it be early or late, for experience has taught that any relaxation in their vigilance has often resulted in a fatal issue.

The pathology of influenza has not been fully ascertained; but this disease corresponds to all conditions dependent on a special micro-organism as the cause and in which the bacteria enters directly into the circulatory system. Very little is known regarding the mode of activity of the bacteria: the constitutional symptoms suggest toxemia, but the nature of the toxins is obscure. With such conditions existing there is always the possibility of serious after-effects.

The presence of bacteria and their toxins in the blood are always factors in lowering vitality and the general resistance. In many cases other diseases which have lain dormant have become active; and it is just such conditions that arise long after the patient has recovered from the acute stage of influenza.

The complications of influenza are very numerous and are all known to any practitioner. The most vital point to consider is the time of their most frequent occurrence, and the exception to this; for while they occur as complications during the acute period, the same condition may occur as sequelæ during convalescence, or later. Thus, pleurisy with effusion and, later, empyema becoming manifest after the patient had apparently entirely recovered. Pneumonia, both croupous and broncho-pneumonia, are among the most fatal sequelæ. Pericarditis, peritonitis and arthritis are occasionally met with—the latter more frequently after the acute stage has entirely subsided. Acute nephritis frequently occurs, and lasting long after the acute and convalescent stage of influenza. This condition usually tends to a complete recovery. There are exceptions to this, however, as it may terminate in the most fatal kidney lesions.

One of the most pronounced after-effects of influenza is prostration; this is in a degree altogether out of proportion to the symptoms and the dura-

tion of the attack. This symptom clings to the patient long after convalescence; and, in a few cases, melancholia and other mental disorders have existed.

Neuritis, myalgia and neuralgia are among the most frequent after-effects, often leading the patient to believe another attack was impending. Gastric and intestinal symptoms are often met with as late symptoms. Otitis media, conjunctivitis, iritis and inflammation of frontal sinuses are frequent after-effects. These are the more important conditions which may follow an attack of influenza. There are, however, many trifling symptoms which annoy our patients, viz.: sudden pains in joints, an inability to move about with the same ease as before, a general languor and lassitude that renders patient unable to carry out the ordinary duties of life without great discomfiture, frontal headaches, flashes of heat, chilly sensations and a general indifference to everything.

In the female functional disturbances of the internal genitals frequently occur. Dysmenorrhœa, amenorrhœa and ovaritis are the most common. Metritis and endometritis are occasionally met with.

The nervous system is profoundly affected for an indefinite period after an attack of influenza, and this fact explains the many functional changes.

It will be seen that while an attack of influenza is generally short in duration, its after-effects may be wide-spread, of long duration, and many times fatal.

VARIOLA.

By A. H. Ohmann-Dumesnil, St. Louis.

SMALL-POX, or variola, is, beyond all doubt, one of the most dreaded diseases which afflict the human race. It has been known for centuries, and its ravages have been such as to decimate populations. It has been the most powerful factor in wiping out the North American from the face of this country. It has established for itself a reputation which has imbued peoples and nations with a wholesome fear of it and its depredations. It is not only among barbarous and savage nations that it has manifested its virulence, but in a manner as marked among the civilized and enlightened. It is only, comparatively, of late years that it has ceased to be the scourge that it formerly was. There need be but little surprise at its rapid spread and the great mortality attending it, when we only bear in mind that variola is easily contagious, and eminently so, the very air seeming to carry the contazium with it. Of course, this is merely apparent, as the true source of inoculation exists in all the products derived

from the skin, the scales separated from the integument, as well as the crusts, being capable of producing the disease. For this reason ambulant cases in convalescence are to be dreaded as much as those in the height of the attack. Small-pox has been looked upon as to be dreaded as much as the plague or pestilence, and what has added to the dread is the fetid odor which is perceptible in a very marked degree. This odor is what has suggested to the superstitious the idea that the unfortunate sufferer was decomposing, and practically a putrefying corpse, although living and breathing. Such ideas would naturally engender panics, and, as a result, the patients were deserted and left to die alone and unattended. Another circumstance which has always aided in increasing the terror caused by the disease has been the scarring, pitting, and destruction of tissues or organs, following so many cases of recovery. In former times epidemics were engendered by the huddling of population, free intercourse, and general filth and filthy habits. In more modern times a prolific source of the spread of small-pox was the placing of patients with variola in the general wards of hospitals. Not only did this tend to spread the disease within the walls of the hospitals, but without, by means of the visitors who are always numerous in large public hospitals. In other words, isolation was not practiced, and its beneficial effects did not seem to be known or be appreciated to their fullest extent. Now that variola is not so prevalent as it formerly was, thanks to vaccination and better hygienic conditions, it is a matter of some importance that cases should be promptly recognized, in order that any possibility of the spread of the affliction may be prevented.

Among the symptoms which should always arouse suspicion and direct especial attention to any case are the prodromata. They are of such a nature as to easily lead to the idea that an exanthematous or eruptive fever is about to declare itself. These prodromic symptoms are of such a marked character as to be easily recognized in a general way, even by the laity. In addition to the general malaise, fever, restlessness, and general irritability of temper, there exist two well-marked symptoms in variola—an intense headache and backache, which seem well-nigh insupportable. The bowels are constipated, a diarrhœa being but very rarely observed. In women menstruation is apt to declare itself unexpectedly. Often a general flush overspreads the skin. In ambulant cases all of these symptoms may be but faintly marked or entirely absent, although anorexia is generally present in all cases, in a more or less marked degree. These symptoms are simply a notice which is furnished that infection has taken place, and, as a rule, they progressively increase in severity. This period of incubation is not one easily determined, and is, as a matter of fact, a variable quantity. It is usually looked upon as oscillating between seven and nine days. Its termination is ushered in by an increased temperature, which may or may not be preceded by a chill, and the appearance of the characteristic eruption.

The following table will be found useful as an aid to determine from the prodromata what one of several exanthemata the physician is called upon to pronounce upon and differentiate:[1]

[1] This table is taken from the Illustrated Dictionary of George M. Gould, A. M., M. D.

TABLE OF THE EXANTHEMATA.

Name.	Period of Incubation.	Stage of Invasion.	Time of Appearance of Eruption.	Character of Eruption.	Duration of Eruption.	Location	Desquamation.	Duration of Disease.	Convalescence.
Erysipelas.	Few hours to 3 or 4 days.	1 to 3 days.	Within 24 hours.	Efflorescence; bright red; polished; with well-defined raised margin.	4 to 8 days.	Face.	Branny, or in large flakes.	1 to 3 weeks.	Crisis.
Measles.	10 to 12 days.	4 days.	4th day.	Macules; small, dark-red, with crescentic borders. Complete in 24 hours.	4 to 5 days.	Face; then downward over body.	Branny; 8 to 11 days.	2 weeks.	Crisis.
Roetheln.	8 to 17 days.	24 to 48 hours.	Within 48 hours.	Macules; rose-colored; rounded; discrete.	3 days.	Face and scalp; then downward over body.	Slightly branny.	4 to 7 days.	Crisis.
Scarlatina.	1 to 21 days.	1 to 2 days.	Within 24 hours.	Diffuse; scarlet; punctate.	7 to 10 days.	Neck, chest, face; then over body.	Scales or large flakes; about 1 week.	2 to 3 weeks.	Lysis.
Typhoid Fever.	5 to 35 days.	6 to 8 days.	7th day.	In crops; rose-colored, lenticular spots.	Each crop 3 to 5 days; last 10 to 20 days or throughout the whole course of the fever.	Abdomen, chest, and back.	Slightly branny, or none.	3 to 4 weeks.	Lysis.
Typhus Fever.	4 to 12 days.	5 days.	Usually 5th day; may be on 3d, or not till 7th day.	Measly spots; petechiæ; streaks; color, mulberry red.	Few days, or may last throughout the course of the disease.	Sides of chest and abdomen; arms; back.	Slightly branny.	2 to 4 weeks.	Crisis.
Varicella.	4 to 14 days.	1 to 2 days.	Within 12 to 24 hours.	In crops; vesicles.	5 to 8 days.	Back, chest, arms.	Crusts; 5 to 8 days.	2 weeks.	Lysis.
Variola.	8 to 14 days.	3 days.	4th day.	Umbilicated pustules.	21 to 25 days.	Face, and over body.	Crusts; 12 to 22 days.	4 to 5 weeks.	Lysis.

Of course, this table is only approximate, and great care is always necessary in formulating a diagnosis and giving a pronounced opinion, for we occasionally find some cases which are more or less abnormal and aberrant and differing somewhat from the classic type.

As has been already stated, the first eruption which shows itself may be a diffuse erythema; but, usually, it is one which is papular. These at first show themselves in the form of pea-sized, dusky-red spots, which are not above the level of the skin. At this time already the peculiar shotty feeling is imparted to the fingers which are passed over this macular eruption. Later on each macule is transformed into a conical papule which is also of a dusky-red color. The same shotty feeling is imparted when they are touched. There is no particular pain elicited in connection with these lesions unless marked pressure be employed. The feeling which is experienced by the examiner when he touches the papules is as if there were large bird-shot under the skin. It is very marked and is peculiar to variola. In other eruptions hard papules may be encountered but they feel upon or above the skin and not under it. This is one of the symptoms which has been insisted upon in order to make a positive diagnosis of the disease. It is claimed, and perhaps with good reason, to be pathognomonic. At all events, it is of sufficient importance to arouse suspicions in regard to the true nature of an exanthema, and a case presenting such should certainly be closely scrutinized and carefully watched. The portions of the body upon which the first manifestations of small-pox show themselves are about the wrists, upon the chest over the sternum, and the face. This, of course, is not an invariable rule, for, sometimes, the first evidence of any eruption shows itself in the groins and axillæ or at their borders. So that it is good practice to always examine the entire body if there be any suspicion of variola being present, or if there be symptoms sufficient to arouse suspicion of the presence of an exanthema.

In a comparatively short space of time, say two or three days, the eruption will have become disseminated and attained the full measure of its distribution. It is then that a metamorphosis is observed to take place. The papules change in their nature and are seemingly replaced by vesicles which are a little larger, perhaps, than the lesions which formerly occupied the same sites. Each lesion is surrounded by a rather bright-red areola which is sharply defined against the unaffected skin. As a rule, these vesicles are discrete in their distribution and show no tendency to coalesce. When they do coalesce, it is after umbilication has taken place and is always a more or less serious symptom, evidencing a want of tone in the tissues. In Figure 1 is shown a good example of the vesicular stage of variola. It will be noted that there is no eruption on the chest of one patient and very little on that of the other. The limbs and faces show proportionately more vesicles. These vesicles have a conical form, primarily, but this does not persist long. A change manifests itself in the way of a central depression at the apex, and this depression is known as umbilication. This is regarded by the large proportion of physicians as an unfailing and pathognomonic sign. And yet, cases occur in which it is absent; and, on the other hand, there are vesicular eruptions in which there is umbilication of some of the vesicles and no variola present. The vesicles, in variola, are filled with a translucent fluid and their walls are

well distended at first; later on, some of the fluid is absorbed and this it is which aids in producing the umbilication. The translucent fluid soon becomes more opaque in its appearance and gets to be yellow in color. In other words, the serum is transformed into pus and the vesicles become

FIG. 1. Variola (Vesicular Stage).

pustules. Whilst this transformation is going on a certain amount of absorption of serum takes place and the umbilication becomes still more marked. In some cases the walls of the lesions become flabby, and this is always a bad sign. The absorption of the serum still continues and is then followed by desiccation. This latter process is progressive and its

final outcome consists in the formation of crusts. The appearance of a case in this stage of the disease is shown in Figure 2. As will be observed, the entire body and face is covered with the crusts and the patient is in a state of convalescence. It is in this case that particular care must be taken not to expose any one to contagion.

One of the most marked symptoms of variola, from the onset of the eruption to its final disappearance, is the intense itching which is present. It is constant and intolerable and a source of agony to the patient. Those who have experienced this, state that it is simply indescribable in its tortures. Scratching affords but little relief, and it is a most prolific cause in the production of subsequent scars in the form of "pits," linear or corded

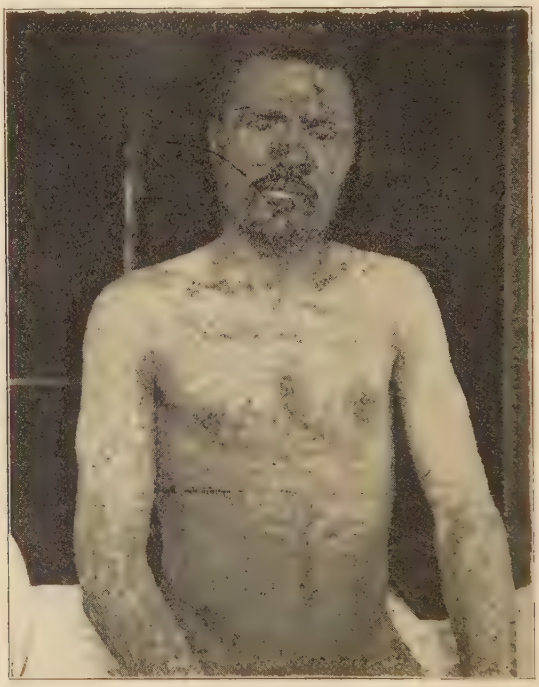


FIG. 2. Variola (Crustaceous Stage).

cicatrices, or deeply-depressed ones. These scars are also due to the erosive action of the pus; and when the pustules coalesce, superficial ulcers are apt to form. The results of these are to be seen in the unsightly seams and scars which occur after recovery in some severe cases. The itching which is present in convalescence, in the crustaceous stage is very apt to be a source of great danger. When it is taken into consideration that the scales and crusts are active as media of contagion, it can be easily understood how the scratching of a patient may separate and scatter them about in such a manner that others can easily get in contact with them. This is a very potent reason for keeping small-pox patients isolated until their convalescence is terminated and the skin restored to a complete state of health. Not only this, but his clothing, bedding, sheets—and, in fact,

every article which has come in contact with him—should be burned, and those object susceptible to the treatment should be subjected to the strongest antiseptics in order to ensure the certainty that all possible danger of contagion has not only been removed but destroyed. It is in this way only that the so-called *contagium* can be eliminated.

There are some varieties of small-pox which occur which are far from classic in type. The confluent form is particularly severe. In these the pustules become confluent and large blebs with sero-purulent contents occur. Temperature has a high range, as high as 107° or more, and convulsions may occur. Albuminuria is marked, the urine being scanty. In such cases the hair falls out and the nails drop off; and if the purulent process has been sufficiently developed, they will not always grow out again, or only partially. Another variety which is always of a serious character is the hemorrhagic. In this the several lesions are more or less hemorrhagic, and constant vomiting may manifest itself. It is most common among drunkards, the old, and in cachectic subjects. The so-called malignant variola is a variety of this, which is not only most severe in form but generally quickly fatal. Convulsions and coma, resulting in death, occur before the characteristic eruption is observed. The temperature will rise up to 110°, and there is constant vomiting with occasional diarrhœa. In some cases the eruption appears, the papules being of a dark-blue color and surrounded by a purpuric areola. There is hemorrhage from the stomach and bowels, and the urine is loaded with albumin. Finally, there is hematuria. This last variety is that which is ordinarily denominated "black" small-pox, although the term is also applied to such as die before the appearance of the eruption. In these, a few hours after death has taken place, the body turns black. This sudden change is one calculated to send terror to the heart of the uneducated and shake the nerves of even an educated layman unacquainted with this peculiarity in the course of the disease. Such cases, however, are not frequently seen nowadays, although as recently as June 16, 1898, Dr. E. B. Glenn reported the occurrence of such a one in his practice to the Buncombe County Medical Society, of Asheville, N. C. Modern conditions and treatment will undoubtedly make the occurrence of such a case a rarity.

Vaccination is the prophylactic for variola. It is only efficient to prevent the development of the disease and entirely inefficient to arrest it once it has begun to develop. It is even a matter of observation; and I have seen it that once variola has been acquired, it will progress unchanged and the characteristic vaccine vesicle will form and declare itself. Nevertheless, under proper conditions vaccination would prevent the occurrence of small-pox. Of course, a simple vaccination is not sufficient, but revaccination should be practiced until the individual is refractory to it after successive vaccinations. This is only efficient for a certain number of years, and at their expiration, say five or six, vaccination should again be practiced. The immunization which it confers exhausts itself and must be renewed. It is the same with variola. It immunizes for a certain number of years only and the individual again becomes susceptible. There is one in St. Louis who has had small-pox seven times and expects it again. Nevertheless, the good effects of vaccination may be judged from statis-

tical reports. Condomine records,[1] that small-pox destroyed, maimed and disfigured a fourth part of mankind. One boy in nine and one girl in ten died from small-pox. In Europe, on an average, two thousand deaths from small-pox occurred to every million living. Six millions out of every twelve died in North America, and two-thirds of the population of Greenland. Before the era of vaccination the death-rate from small-pox was about the same in Sweden, England, Prussia, Austria and Belgium, the average being about two thousand per million. On the introduction of optional vaccination, mortality dropped everywhere to about four hundred per million. When compulsory vaccination was adopted in Prussia, England and Sweden, the mortality was reduced from twenty to forty per million. Austria and Belgium retained the old optional system, retaining also the old mortality statistics.

After admitting the undoubted value of vaccination, a question which naturally arises is, should bovine or humanized virus be employed? It is true that more rapid effects are obtainable from the latter, but this advantage is more than counterbalanced by the possible dangers which may follow in its wake. The transmission of leprosy is certain if the lymph of a vaccine vesicle on a leper be used. As a matter of fact, competent leprologists maintain that this method never fails where others have failed. Of course, there need be but little fear of this contingency in the United States. There are, however, two other troubles which are very prevalent and which no physician can ever justify himself as producing, even inadvertently. These are tuberculosis and syphilis. The necessity of inoculating with humanized virus or from a "scale" may have existed at one time, but it disappeared long since. In these days, when bovine vaccine virus is so readily obtained, there can exist no excuse for using any other kind. Those who furnish it are able to guarantee its purity, and as it is now put up in sealed tubes, no fear or hesitation need be felt in its use. The day to practice prophylaxis has arrived, and it can be successfully carried out without any fear of failure or hesitation on account of any possible danger of inoculating some other disease which is, perhaps, worse than small-pox would be had vaccination not been practiced. Vaccination is the true prophylactic method, and the virus which should be used is, beyond question, the bovine.

The treatment of small-pox is, in great part, symptomatic. A great many complications may be prevented by the adoption of very simple measures. Thus, secondary fever, pustulation and its consequences may be prevented by excluding all white light. Deep red glass windows or curtains will accomplish this, as the violet or irritating rays are thereby excluded. The period of suppuration is very much shortened, and there is no pitting, or very little. The fever is to be treated like any other fever. Occasionally, alcohol will be found of value, especially in grave cases, but should be administered with caution. The headache and backache should be treated with acetanilid, phenacetine, or some similar agent. Chloral or, better yet, the bromides will act well in overcoming insomnia or restlessness. One of the principal things to do is to husband the forces of the patient as much as possible. To accomplish this light nutritious food is to be given, and, in addition, some assimilable preparation of iron. A

1 *International Medical Journal of Australasia.*

symptom which needs particular attention is the itching. Various preparations have been recommended for this, but none is more than a palliative at best. A one per cent. ointment of salicylic acid in lard is employed by some. Others use a one-half per cent. ointment of camphor in lard. One source of the relief which these ointments afford is the lowering of the temperature brought about by the inunction. To prevent pitting of the face various methods are employed. Thus, each pustule is opened and emptied; or flexible collodion, glycerole of starch or simple cerate applied in a thick coating. As has been stated above, the scales or crusts are a source of danger to others; and in the desquamative stage the entire body should be well oiled with some bland oil or a very soft, soothing ointment. This will prevent the scales from flying about, soften the crusts and greatly add to the comfort of the patient. There are many other little points connected with the treatment of variola; but they will readily suggest themselves to the practitioner. If the general principles be carried in mind, there will be but little difficulty experienced in the proper treatment of a case of the disease and in carrying it to a successful issue.

MAN'S INHERITED MARTYRDOM—A FITFUL STUDY OF DEGENERATION.

By Dr. Warren B. Outten, of Saint Louis.

[CONTINUED FROM THE DECEMBER ISSUE.]

CHAPTER VIII.

Theodorus.—And now, sirs, you have heard the story; and we have examined this man, and find him, forsooth, a neurasthenic degenerate—shown in many ways by the mental evidences of his condition, but not so plainly by any physical stigmata or marks. He hath a dread, not only of heights, but agonizing spells toward other things. He has emotional attacks, constantly accompanied by bodily symptoms, pains over his heart, paling and flushing, moist hands and feet; chills and tremors, and swooning at times. His mind is in a state of nervous exhaustion—a most sad and helpless plight.

A man's will is a man's power. Aye, his joy, and the very essence of life as a healthy being. The will makes possible man's genius, his reputation, his usefulness, in this strifeful life. Yea, it gives action—the breeder of all human effort. Nay, then, this man, whom we now consider, shows but the fated and fatal weakness of a human brain. His mind was born already vanquished; for he has inherited an impotent will. With him, to be weak, is, indeed, to be miserable; for his brain, as his story proves, is in a state of nervous exhaustion—that is, enfeebled and helpless; for his will hath not power or strength to act as in health. Truly, his will is diseased; yet, 'tis plain to see, his intelligence still bides with it—in full power to know his own thoughts and to understand his mind's doings, although it but fails to control his erring will. Nay, his mind is

beset with fixed ideas, which he cannot banish. Aye, too, he is a degenerate, in that he has grown worse than the ancestor from which he sprang, through heredity. Nay, 'tis sad, but true, that even an inherited and nervously exhausted brain, as in this person, may be intelligent, bright, and, forsooth, even quick-witted. But with these mental goods come the towered ills of infirmity; for they are foolishly timid, with a tremulously weak will; for their minds o'erflow with feeling, agitation, perturbation, and an intense susceptibility to disturbing impressions. They are tyrannized by ideas, thoughts, and emotions, and are, at all times, easily and readily worried and worked-up by absolutely nothing. They are oft infirmity's own; racked with pain, disordered nerves, neuralgia, heart beatings, exhaustion, and a general weakness. Thus, 'tis true that the great bulk of brains in nervous exhaustion, enfeebled and helpless, are inherited, and have grown worse than those from which they came; thus become degenerates. And this degeneracy is shown in defects of the head, ears, eyes, or other physical parts. They live in this condition for indefinite time. Their trouble, now and then, abates in severity; and, at times, go so far as to desire, nay, even pray for, death.

THEO CELSUS.—Alas! Woe to him whose brain is drained of nervous force; for this but seems a will's deep disease. Such men think; they know; aye, they can tell their woe, and bewail it in vain longing. For, here, action doth seem to give way to inaction; and inaction is but dead result. Aye, a soul robbed of its will is a soul entombed. Their grief is not tuned in hope; nor is there any comfort in their adversity. They have no energy; for hope is lacking. Aye, to me it doth seem that hope is, indeed, the nearest offspring of will; for hope, alone, makes us willing to live; while in a brain drained of its nervous force, the lack of hope makes them willing to die. Hope may be as cheap as despair to the healthy; but to these poor brains in a state of nervous exhaustion, hope is beyond the purchase, and despair is a welling gift. 'Tis said that "hope maketh the fool rich." But their lack of intelligence doth but make them poverty's jade.

PARA BLAR.—True, and sadly true; for this is, indeed, wretchedness. But let's get at the root of the trouble! Now, then, as I understand, the will is that faculty, endowment, or function of the soul, with which it is made capable of choosing, preferring, or selecting one, two, or more objects. The will represents the power of the mind; volition, act—that is, it is will in action. The will is the ruler; volition but the servant of the will.

Thus have I read: we have two kinds of diseased will.

Now, then, forsooth, listen! When the brain is in a state of nervous exhaustion—that is, enfeebled and helpless—this brain's mind is beset with an idea, emotion, or irresistible bent, through lack of will-power to restrain. This, then, is impulse, or that which acts unprompted, and instinctively.

Again, when the brain is similarly in a state of nervous exhaustion—that is, as stated, enfeebled and helpless—and this brain's mind is likewise beset with an idea, emotion, or supposedly impossible but desired duty, through a lack of the will's volition—this, then, is loss of will.

Thus, the former brain's will-power acts as an impulse—that is, blindly and instinctively; while the latter's incapacity is due to a want of volition; for volition is but the desire to act.

The will acts either sluggishly, or not at all.

Nay, then, let us see how the healthy brain performs its function.

Thus, the healthy brain can either act, or restrain action. Hence, when the brain is crowded with ideas, these ideas can be either fixed in the mind, or rejected, just as the will prefers; while the brain in a state of nervous exhaustion acts altogether differently. A weakened will-power tries, in vain, to drive away an idea induced by instinct; hence, there arises mental strife between self-controlled will-power and strong impulse.

In this test of mental worth lies the turning point in the conflict with torment and fear, which results either in a yielding to the impulse or in nervous exhaustion.

Now, the brain in a state of nervous exhaustion, acting under the impulse, has its mind invaded by ideas self-acting, under the influence of a diminished, halting, or suspended volition.

The fixed idea is the germ of an impulse's besetment. Now, when this will is thus beset, there comes either impulse or no will at all; and thus there arises what we may call a soul's moving power, terminating in paralysis, or in irresistible act, which is impulse. All besetments of impulse have an intellectual source. Any idea that is instinctively or spontaneously born within us, no matter what it may be, may become fixed in a soul so enfeebled, and hence are called besetments. Such besetments may be as numerous as thoughts, and thoughts are as numberless as the sands of the sea. Thus it is that the tyranny of the fixed ideas oppress the nervously-exhausted brain—as constant grief and misfortune.

THEO CELSUS.—I pray thee, stop, and give me but time for thought and breath; for here haste courts worry and confusion. For the brain's action doth ever well in wonder, when under close consider. My mind, when in query about its very self, begets strange and easy muddle. Hence, I must go slowly, if I would but comprehend. God's greatest created substance commands our most grave and powered thought. Now, I pray thee, patience! But let me state what I do but mean, which is the brain's healthful action!

Nay, I earnestly court thy correction, if I do but err. Thus, the brain's capacity to feel or perceive is aroused and put in motion by the various thoughts, ideas, or emotions coming to it, where they finally produce an indefinite number of more or less complicated modes of action. Thus, two kinds of counter-action are produced: first, the counter-acting tendency to restrain or hinder action; second, that tending to strengthen with new force or impulsion; the act suggested by the impelling idea, thought, or emotion. That is, the certain thoughts, ideas, or emotions are, as it were, felt by the brain, which hinders or restrains such as it desires, or puts into action such as it determines should be so.

Now, then, let me ponder; and, perchance, I can make it plainer still. Thus, then, when the brain has certain thoughts, ideas or emotions, it hinders or restrains some of them, while it impels others, as it sees fit. Nay, then, perchance this will, in smaller numbers, prove as ease's explanation. Thus, in health, the mind wills or wills not, as it sees fit; and, on the contrary, in disease, the mind wills or wills not, but as disease compels.

HEINE LANIUS.—Forsooth, I but admire thoughts which grow with age; for they seem as marveled inspiration. What can be truer than the

assertion of Epictetus that "there is nothing good or evil, save in the will." Aye, this assertion depicts a healthy will, as well as one diseased. Nay, thy nerve-exhausted, degenerate brain cannot force its will; for that but controls the mind.

Can there be deeper misery, more distress, or greater worry than when one who might will to do a thing is utterly incompetent to act out, or do that thing?

Now, impulse, forcing a soul's blind action, courts vagaried result; and Hinton doth wisely state: "I venture to suggest that the most developed man is he who has the least reason for not simply obeying his impulses; or, that perfect impulses mark the perfect man." For impulse most oft marks the action of a will diseased, and this action hath but blind purpose.

THEODORUS.—Order is regularity's rule, method's maker, and a rare gift of intellect; and this question but demands thought and order that ease may attend elucidation.

The brain's nervous exhaustion, we are told, doth, as a rule, come in heredity. The brain thus hath ever complete knowledge of what passes in its own mind. The attendant mental anxiety bides with consciousness. Now, then, this trouble may abate, and there may occur, at intervals, periods of ease. Yet, these are indefinite in duration; for the trouble persists throughout the entire life of the afflicted; and, in truth, keeps its soulful nature. Persons so afflicted do but constantly and unceasingly dwell upon their mental infirmity, which, at times, may lead to the direst consciousness.

These, then, are the features of this mind's besetment. Vices acquired and vices inherited beget a mind's affection or nerve's disease. All thrive in fruitful soil and under stressed circumstance. It matters not whether they act but slowly or rapidly, still there comes nervous exhaustion.

Now, then, we find this but leads onward to a mind overworked, great fatigue, excessive vexation, chagrin, humiliation, depressing circumstances, and other wearing causes. The degenerate's besetments, as has been said, are numberless; although they rarely occur singly. Now, then, here marvel comes; and if it were not infirmity, it would be utter nonsense, in these besetments of fear. Aye, it may be true, that fear comes from ignorance; but here it springs from heredity and weakness.

Consider this tall, dignified-looking, and intelligent man, who, forsooth, is afraid of glass—nay, afraid of a piece of glass. Why? He could not explain: yet, fear is ever manifest. Here, anon, is one whose heart beats in excitement; whose face pales and flushes; who hesitates and trembles when he touches the door-knob, or a piece of metal. Another is in trepidation or fear from feeling hair, or the down of a peach. Another has eternal dread of wide space; another of narrow space; and still another is afraid of needles, or of pointed things. Similar vagary exists nowhere but in the brain. Thus does the brain, in nervous exhaustion, breed besetting ideas which tyrannize over our living purpose.

[TO BE CONTINUED.]

NEW YORK LETTER.

Dr. Ramon Guiteras read a paper on "Some Observations on Stricture of the Urethra," before the Medical Society of the County of New York, December 26th. He stated that strictures were formed in cases of chronic urethritis as follows: The urethral epithelium is thrown off, leaving the urethra denuded in certain places. This allows the escape of urine into the subepithelial layer. To prevent the urine from soaking into the tissues, an inflammatory exudate is excited, barriers of lymph are thrown out in the places where leakage takes place, thus forming plastic splints, which ultimately become organized tissue.

Subjective symptoms are the gleety discharge, twisted stream, frequency of urination, pain and tenesmus (if much bladder irritability or cystitis is present), retention of urine, incontinence. This latter symptom is caused by an overflow in cases of retention following obstruction, and is divided into two varieties: simple dribbling, due to the inability of the urethra to empty itself and the loss of urine in considerable quantities, as an overflow in cases of retention.

The objective symptoms are determined by means of metal sounds, bougies a boule, filiforms and olivary-tipped bougies. Otis has shown that the size of the urethra is in proportion to that of the body of the penis, and that a penis three inches in circumference should have a urethra of sufficiently large caliber to admit a thirty French sound—that is, thirty millimeters in circumference. The speaker's experience had been that a small meatus was most frequently found in those circumcised in infancy; if a meatus is found to be too small to admit sounds, it should be cut; although he never cuts a meatus above a thirty-two French, as he considered that sufficiently large for the man of to-day. Strictures are usually found either in the deep urethra (the bulbo-membranous portion), or in the first two and a half inches of the pendulous portion, as it is here that the urethra is more vascular, and gravity favors congestion there.

An enlarged prostate is at times mistaken for a stricture, and cases are frequently seen where physicians state that a patient has a stricture of the prostatic urethra, because a straight catheter or sound fails to enter the bladder on account of an enlarged middle lobe. A Coudé catheter, however, can usually be slipped over this impediment.

The complications may be chronic urethritis, false passages, rupture of the urethra (extravasation), fistulas, urethral fever, retention, cystitis, incontinence, stone, tuberculosis, and pyelonephritis.

In regard to the treatment of strictures of the urethra, he summed this up in a few words. Every stricture that is permeable and yielding, and can be dilated up to the normal size of the urethra, should be treated by this means. If strictures do not yield to dilatation, they should be cut. Dilatation should be accomplished by sounds, dilators, or bougies. The Oberlander dilator is considered the best.

Stricture operations are divided into two great classes: internal and external urethrotomy; besides which, we have perineal section, or an opening into the urethra through the perineum, where no guide can be passed through the strictured portion. Strictures of large caliber, over fifteen French, in the anterior urethra, which do not yield to dilatation, should be cut with

an Otis urethrometer. Anterior stricture of small caliber should be cut by the Maisoneuve. Deep strictures should be cut through the perineum (external urethrotomy).

Dr. Guiteras' method of treating false passages situated in the deep urethra has been as follows: After opening into the urethra by the perineal incision, he passes a director or guide from the meatus down and through the urethra into the pockets; through the perineal opening he feels the point of the instrument, and he cuts down upon the groove of the instrument from below. He has often opened them upon the end of a sound; but a grooved instrument is better, as the incision is more accurate and complete. He also has opened them with scissors from below, the point of one blade being in the pocket and the other in the perineal wound. One might think that by opening pockets in this way that the compressor urethra muscle would be cut through more than once and its function interfered with; this may occur, although the speaker had never heard of such an instance.

Fistulas complicating stricture usually occur behind them. Dilatation will occasionally cure them, for when the extra pressure, caused by the stricture, no longer exists, they are allowed to heal. For the radical cure the knife must be relied upon. If the fistula is seated in the perineum, a perineal urethrotomy should be performed, after which the fistula should be incised through into the peritoneal opening, and the false membrane lining it should be touched with a strong solution of carbolic acid. If there is danger of cutting an artery by this method, it can be treated by passing a needle into it connected with the negative pole of a galvanic battery; this will set up an adhesive inflammation and allow the walls to grow together. In some cases, where the fistula is situated right over the perineal urethra, the membrane lining the walls can be dissected away up to the urethra and the edges sutured together, thus entirely obliterating it.

A very rare book was presented to the New York Academy of Medicine by Lothar Voss, one of its honorary fellows. Dr. Voss was one of the first to introduce tracheotomy as a part of the systematic treatment of croup. The book treats of the lymph vessels, and is by Gaspar Asellii, who discovered these vessels in July, 1623. The book was printed in 1627, and was the first that gave colored anatomical plates. The book was reprinted twice, the third edition appearing in 1640, but the two later editions were decidedly inferior to the first. There is one copy in the University of Leipsic, and a defective copy in the library of the University of Breslau. The book given to the academy was one of the two copies now in existence, and was one of the first edition. The surgeon-general's library, Washington, D. C., contains a copy of the inferior third edition of 1640.

The following officers were elected to serve the New York Academy of Medicine: President, Dr. William H. Thompson; vice-president, Dr. Herman Knapp; trustee, Dr. Edward G. Janeway; committee on library, Dr. A. Caillé; committee on admissions, Dr. Reginald H. Sayre; committee for the trustees, Dr. W. F. Cushman.

E. FRANKLIN SMITH, M. D.

308 W. Forty-fifth street.

SURGICAL SUGGESTIONS.

Obstacles to Union in Fracture of the Patella.—1. Separation of fragments due to (*a*) retraction of quadriceps; (*b*) effused blood. 2. Tilting of fragments. 3. Rupture of expansions of vasti and capsule of joint. 4. Prolapse of prepatellar tissues into the breach. 5. Atrophy of quadriceps (*a*) from disuse; (*b*) arthritis; (*c*) contusion of muscle; (*d*) effused blood in joint. 6. Arthritis of joint. 7. Adhesions of patella.—*Treatment*, November.

Indications for Venesection.—Dr. Moritz Kaeser (*Weiner klinische Rundschau*) gives the following indications for venesection:

1. In affections of the central nervous system, such as cerebral hyperæmia, apoplexia cerebri, inflammation of the cerebral membranes.

2. Kidney diseases in the stage of œdema and uræmia (Saccharjin and Hoffmann).

3. Cardiac disease of valvular origin. In great disturbances of circulation in which the venous system is overtaxed and the arterial pressure raised (Leibermeister).

4. In pneumonias with an exceptionally severe onset, absolutely in the first stage.

5. In various stages of chlorosis (Dyes, Wilhelmj).

Treatment of Gonorrhœa.—Dr. W. P. Carr (*The National Medical Review*, November, 1898), in the course of an article on this subject, says:

"Soaking the penis several times a day for ten or fifteen minutes in water as hot as can be borne, as recommended by Milton, has a strong tendency to reduce the inflammation and shorten the attack, and also relieves pain. This may be done simply by using a cup of hot water and adding to it from time to time hotter water from a small pitcher. The gonococcus is said to be killed by a temperature of 105° F., and it is quite possible to raise the temperature of the whole pendulous portion of the penis to that degree.

"Dr. W. F. R. Phillips informs me of a case where the inflammation was confined to the outer portion of the urethra, which he believes to have been sterilized and cured in this way."

Injection of Arsenious Acid Into Malignant Growths.—Dr. John A. Wyeth, in a paper read before the New York County Medical Association, reported the case of a ranchman, thirty-seven years of age, who had been in excellent physical condition up to July, 1897, when he had been thrown from a broncho, injuring the left hip. He was in bed for three weeks, and on crutches for six weeks more. In August of the same year he began to suffer from nausea and vomiting, and experienced dull pain in the right iliac fossa. On incision for a supposed appendicitis, in December, 1897, malignant disease was discovered. On examination by Dr. Wyeth, a tumor was found beneath the line of this previous incision, and projecting from the center of the scar was a hard, red nodule, apparently a sarcoma. At the man's urgent request, an exploratory operation was due, and the scar tissue in the sarcomatous growth, together with a large sarcomatous mass involving the anterior and posterior wall, was removed with a curette. The wound was packed, and the patient recovered without serious symptoms.

Two weeks later treatment was begun by the injection of five to fifteen drops of Fowler's solution of arsenic into the edges of this extensive new-growth. Strange to say, the tumor had materially decreased in size, and at various times portions had sloughed away. The patient's general condition had markedly improved. The sarcoma was attached to the posterior iliac vein. Dr. Wyeth said that ten or twelve years ago he had first made use of injections of arsenious acid in a case of sarcoma of the abdominal wall. It was followed by severe inflammatory reaction, but the man had remained well ever since. He knew of ten or more cases of sarcoma that had been cured by a very violent streptococcus inflammation. In these cases the diagnosis had been established beyond question by a number of microscopists, working independently of one another.—*Abstracted from Medical Record.*

Treatment of Cutaneous Carcinoma.—Gottheil, in his excellent little book on "The Treatment of Skin Cancers," just published by the International Journal of Surgery Company, New York, formulates this résumé of the treatment of cutaneous carcinoma:

1. Cutaneous carcinoma is preferably treated, in the great majority of cases, by caustics, which give the best results, with the least liability to return.

2. Excision is to be reserved for those exceptional cases in which, from location or extent, the caustic treatment is inapplicable.

3. Arsenious acid is the safest, surest and best of caustics at our disposal, and seems to have a specific, selective action upon the cells of the new growth. Pyrogallol may be employed in the most superficial cases.

4. In cases involving the skin alone, arsenic should be used, after curetting, in the form of Marsden's paste.

5. Where the mucosæ are also or solely affected, arsenic can be used by the method of interstitial injection of Hue, or as a paint, as recommended by Czerny and Trunerk. The galvano-caustic paint, the caustic potash stick, and the chloride of zinc, may also be employed.

6. Cutaneous carcinoma, early and vigorously treated by the caustic method is a very manageable disease, and of good prognosis.

Intussusception in Children.—The first attempt at reduction should be thorough and final. This is most likely to be successful if practiced upon the thoroughly anæsthetized child. The method of choice is the slow injection of normal saline solution by gravity, at a temperature of about 102 degrees F., and under a pressure of at first four feet—not greater than eight feet—after ten or fifteen minutes. Inversion and gentle massage aid in accomplishing reduction. Reduction by injection should not be attempted in hyperacute cases which have lasted more than twenty-four hours, nor in acute cases that have lasted twice this time. Immediate operation is safer for such cases. DR. EDWARD MARTIN.

Brain Tumors Complicated With Choked Disc.—Dr. William C. Krauss (*Phila. Med. Journal*) made observations in one hundred cases of brain tumors complicated with choked disc (optic neuritis), and arrived at the following conclusions:

1. Optic neuritis is present in about ninety per cent. of all cases of brain tumors.

2. It is more often present in cerebral than cerebellar cases.

3. The location of the tumor exerts little influence over the appearance of the papillitis.

4. The size and nature of the tumor exert but little influence over the production of the papillitis.

5. Tumors of slow growth are less liable to be accompanied with optic neuritis than those of rapid growth.

6. It is probable that unilateral choked disc is indicative of disease in the hemisphere corresponding to the eye involved.

7. It is doubtful if increased intra-cranial pressure is solely and alone responsible for the production of an optic neuritis in cases of brain tumor.

Fractures of the Skull.—Dr. Pope (*International Journal of Surgery*, April) sums up his experience on this subject as follows: 1. Operate in all cases of fracture of the skull, basilar or compound, and preferably in simple fractures. 2. Expectant treatment is dangerous, permitting injury to the nerve structures. 3. Danger does not exist in fracture *per se*, but in subsequent injury to the nerve elements and tissues. 4 Failure to trephine and immediately remove the existing pressure, depression, hemorrhage, inflammation, or septic infection, may result in the development of focal epilepsy and other cerebral diseases. 5. Little or no danger results from the operation. 6. These rules are doubly applicable to fractures of the base, owing to the danger to vital structures lying there.—*Medical Record.*

The Gynecological Aspect of Bicycling.—Dr. J. W. Ballantyne, in a recent number of the *International Medical Journal*, has made a most complete digest of the consensus of opinion on this subject. He divides the indications for bicycling into two groups; those in which it is recommended, and those in which it may be permitted.

It is to be recommended in:

1. Uterine congestions.

2. Amenorrhœa, in relation with arrested development of uterus or ovaries, with anæmia, chloro-anæmia, digestive disturbances, neurasthenia, chronic diseases, physical or moral shocks, chills, falls, etc.

3. Dysmenorrhœa of the nervous type.

4. Dysmenorrhœa with congestion of the uterus and ovaries.

5. Vicarious menstruation.

6. Fibroid tumors, after the termination of the hemorrhagic period.

It is to be permitted in:

1. Mechanical dysmenorrhœa, congenital or acquired, and in membranous dysmenorrhœa.

2. Uterine displacements (prolapse, flexions and version).

3. Chronic metritis, with *post-partum* or *post-abortum* subinvolution, which is no longer painful and which is in process of cure, but with moderation.

4. Leucorrhœa in anæmic, chloro-anæmic, and delicate women.

Gonecystitis.—Dr. W. Ayers (*New York Medical Journal*), writes on this topic, drawing the following conclusions:

1. That gonecystitis occurs with about the same frequency as epididymitis; the acute form much more rarely than acute epididymitis; the chronic form much more frequently than chronic epididymitis.

2. That, in his opinion, masturbation or sexual excesses can not cause it, unless they have first produced a stricture in or near the bulb.

3. That stripping the vesicle is the only treatment that is of any service in chronic non-tuberculous and non-syphilitic gonecystitis.

4. That the vesicle can be reached and emptied, in spite of the fact that it seems impossible from measurements made on the dissecting table.

5. That we have by this method a treatment whereby we are able to cure a large number of the so-called "incurable gleets."

Indications for Operation for Intestinal Obstructions.—The various conditions for which operations are usually demanded for the relief of those suffering from intestinal obstruction are:

1. Strangulation of the gut by bands, extensive adhesions or apertures.
2. Volvulus.
3. Intussusception.
4. Obstructions due to neoplasms.
5. Compression by tumors external to the gut.
6. Obstruction from foreign bodies, such as gall-stones and enteroliths.
7. Obstruction caused by fecal masses.

FREDERICK HOLME WIGGIN.

The Porro Operation Versus Total Hysterectomy.—1. Total hysterectomy should be performed in preference to supra vaginal hysterectomy with extraperitoneal treatment of the pedicle.

2. The operation should never be performed unless absolute indications are present.

3. The uterus can be rapidly removed by applying clamps on either side and working as detailed in the technique; the difference in time consumed between a "Porro" and an ideal total hysterectomy is not more than a few minutes, because the elastic ligature is dispensed with, and the proper attachment of the cervix in the lower angle of the wound nearly equals the time consumed in ligating the vessels and suturing of the peritoneum after removal of the uterus.

4. When the child is dead *in utero*, the organ should not be opened for the purpose of first delivering it, but the uterus should be removed *in toto* unopened.

The advantages of the total hysterectomy over the Porro operation are:

1. Less danger of infection.
2. Practically no danger from secondary hemorrhage.
3. Less danger of intestinal obstruction.
4. A shorter period of convalescence.
5. Less danger of ventral hernia.

Disadvantages: It has none which will not be shown to be void by a practical test. H. J. BOLDT.

Ranula.—The old way of treating these cysts was by passing a seton through them; and some surgeons still adhere to this plan. It is better to cut a piece out of the cyst-wall by means of scissors, and then destroy the remainder of the cyst by the application of silver nitrate, or the edges of the cyst-wall can be kept back by stitches. J. W. MCDONALD.

MEDICAL NOTES.

Experimental Researches on the Effects of Different Anæsthetics.—*Ether* causes contraction of the renal arterioles, with sequential injury to the renal secreting cells; the kidney shrinks and the secretions gradually diminish till suppression occurs. The general blood-pressure is raised and maintained. Ether, then, is contra-indicated in renal disease, and particularly when albuminuria exists with a tendency to pulmonary œdema.

Chloroform has no effect on the kidney, but has a direct depressing effect on the circulation.

The A. C. E. mixture, if inhaled openly, has the effect of chloroform; if given by a more or less closed method, it combines the depressing effect of chloroform on the circulation with the renal lesions caused by ether.—Drs. W. H. Thomson and Kemp, *Medical Record*, September, 1898.

Should We Drink at Our Meals.—Most persons feel the necessity of adding more fluid to their meals by drinking either ordinary water, carbonated waters, or alcoholic beverages. The more one eats, generally the more one drinks; and the greatest eaters are the greatest drinkers. If drink be prohibited, the amount eaten is less; indeed, on the above very greatly depends the secret of the "Schweinger cure" for obesity. It is a well-known fact that if the appetite is weak and the mind and nerves somewhat relaxed, a drink of water will excite the appetite and stimulate the brain and nerves; and this is due directly to the fluid and not to the alcohol contained, for we find these same facts the same in abstainers.—*Dietetic and Hygienic Gazette.*

Treatment of Cystitis.—(1) Cannabis indica, in full physiological doses, is the best remedy we have for the relief of the distressful symptoms of cystitis; the magical change in the character of the urine under its use indicates probable antiseptic properties dependent upon the resin which it contains.

(2) Antipyrine is an efficient anesthetic and antiseptic, is safe with ordinary caution, and compatible with nitrate of silver when used as an anesthetic before the application of solutions of the latter drug.

(3) Nitrate of silver is one of the best remedies for local use in chronic cases.

(4) Ichthyol is the best all-round antiseptic for local use.—Dr. Louis Maddock, *The Pacific Record of Medicine and Surgery*, November 15, page 112.

An Indian Doctor's Advertisement.—The following account will give an idea of the manner in which the pious Hindoo or Mohammedan, as the case may be, who has become the proud possessor of a British qualification, makes use of the same when he returns to his native heath. This copy of a placard, which has been put up on all the principal roads and at all the public places in Lucknow, was printed in the *Indian Medical Gazette:*

"Dr. M. S. Varis, M. B., C. M., Edin., consulting physician and surgeon. Consultation, all hours free, 9–11 A. M. Share Darvoza.

"Notice.—Dr. Sayad Mahomed Varis, surgeon. 'Good news to thee, O heart; a Jesus-like man has come.' Be it known to the seekers after

bodily health and to those in the clutches of deadly diseases that the Aristotle of the times and Galen of the universe, Dr. Sayad Mahomed Varis, M. B., C. M., after learning the art of medicine and practicing it in Great Britain, has come to this town (Lucknow). He studied for six or seven years in modern Athens, viz., Edinburgh, which is the capital of Scotland, and he obtained the diploma of a physician and surgeon; and there for three years he established himself in practice and performed Christ-like miracles. It is our good fortune that he has established himself here. It is hoped that whosoever will apply to him for treatment will fill his pocket with pearls of health. He lives close to Kaisar Bag, near Share Darvoza, opposite the telegraph office, in house No. 1. Patients can consult him all day."—*Exchange.*

Phenic Acid in Severe Erysipelas.—Fedele reports a case of erysipelas of the face and scalp, with fever at 41 degrees C., delirium, and other alarming symptoms, which resisted the usual treatment, but yielded to hypodermic injections of phenic acid: aq. dist. 100 gm., alcohol 4 gm., phenic acid 2 gm. A hundred and ten injections were required during the eight days before complete cure, a total of 220 centigrams of phenic acid. Luciani ascribes this tolerance to the combination of the phenol with sulphuric acid, producing phenol sulphuric ether, which the organism can tolerate to a much greater extent. Ascoli suggests that possibly in an acute infection the organism has an enlarged protective mechanism at its disposal that preserves as well against acid intoxication.—*Gazetta degli Osp.*, October 23.

Gastric Form of Epilepsy.—*The British Medical Journal* states that Fichaux has collected a certain number of cases showing the existence of a form of epileptic seizure which manifests itself by attacks of gastralgia. This form of the disease has attracted very little notice, Trousseau and Féré being almost the only writers who allude to it. To quote one case in illustration: A girl, aged twenty-two, under the writer's care, apparently in good health, will suddenly cry out with severe pain in the epigastrium, this not being preceded by any other symptom. If standing up, she has time to sit down; she becomes extremely pale, with a slight loss of consciousness lasting for two or three seconds, during which time she is unable to perceive any sensation. On returning to consciousness there is a feeling of fatigue and headache, which lasts an hour or so. Under the influence of bromide these attacks become very much less frequent. In all the cases collected by the author there was this same sudden character in the onset. In the absence of every other symptom, the apparently perfect health of the patient between the attacks is strongly suggestive of their epileptic nature.

Ergot in Chronic Malaria.—A. Jacobi (*Medical News*) says that in connection with malaria there are two organs which have to be considered in the administration of medicines: the blood and the spleen; the former because it contains the sporozoa, the latter because of its sponge-like mass in which it harbors the infected blood and serves as a receptacle of dangers. It appears that a direct effect on the blood or on the plasmodia is

not required for a cure, but that gradually the restoration of the spleen to a fairly normal size, forcing the stagnating blood into a normal circulation with progressive elimination of the plasmodia, is sufficient to open the gate to recovery. He gives ergot in the form of fluid extract (Squibb's), one teaspoonful in whisky and water four times a day. He gives details of several illustrative cases, and formulates the following conclusions: (1) There are cases of chronic intermittent fevers with large tumefaction of the spleen that, after having resisted the action of quinine, arsenic, methylene blue, eucalyptus, and piperine, are benefited by ergot. (2) When enlargement of the spleen is not old and not firmly established, the contracting effect of ergot is noticed within a reasonable time. (3) The attacks will disappear before the diminution in the size of the spleen is very marked. (4) Though temperatures, after the employment of ergot, remain irregular, and now and then somewhat elevated, rigors, as a rule, are not noticed with this elevation. (5) Plasmodia do not seem to disappear from the blood so rapidly as they do after quinine, when the latter is effective. But even while some are still present, the attacks being more or less under control, the patient will feel better. (6) Complicating local pain requires additional treatment with ice, or cold douches, or heat; chronic hyperplasia calls for iodide of potassium or iodide of iron. Digestive disorders may indicate, as they often do when quinine is expected to act, before the employment of ergot, an emetic, or a purgative, or stomachics. (7) An experience extending over forty years, in which he has used ergot in many instances, seems to Jacobi to justify in asserting at least this much: that there are many cases of chronic malaria, apparently intractable, that will get well with ergot. (8) There are cases occasionally in which the return of elevations of temperature after the successful use of ergot makes the combination of ergot and quinine, or ergot and arsenic, advisable, though quinine and arsenic had not been successful previously. (9) Ergot, like quinine, probably by its sudden contracting effect on the spleen, and by the forcing of large quantities of plasmodia-laden blood into the circulation, is, in chronic malaria, when hydræmia and spleen tumor are excessive, capable of bringing on the very first attack of rigors and fever. (10) Recent cases of malaria have got better, or were improved under the extensive use of ergot, but many resisted a long time; that is why acute cases should rather be treated with quinine.

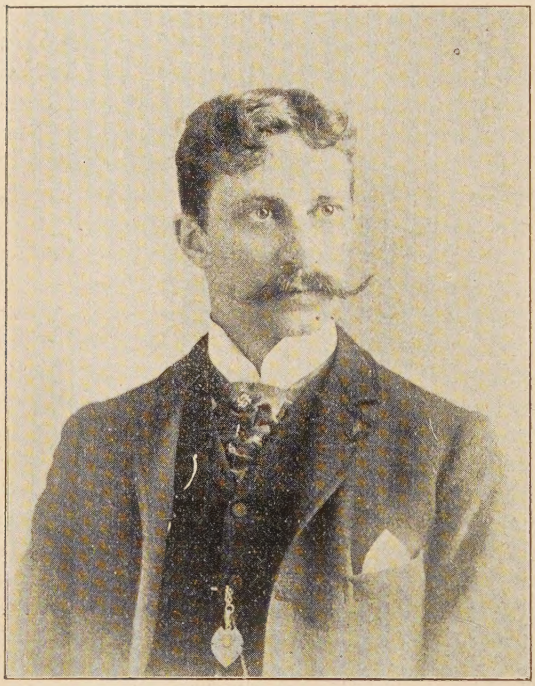
Syphilis vel Gonorrhœa.—While local suppurative syphilitic disease is recognized in the male, the same affection in women does not seem to be appreciated. Anything which is not obviously syphilitic in women is usually attributed to gonorrhœa. I have no hesitation in bearing testimony to the efficacy of mercurial treatment in cases of urethritis in the male and leucorrhœa in the female, which have resisted the usual gonorrhœal remedies.—DR. JOHN A. SHAW-MACKENZIE, *On Maternal Syphilis.*

Nervous Headache.—

℞ Blue methylene (pure) ..... grain ij.
Nutmeg ..... grain ij.
Sig.—Two or three daily, according to the case. LEWY.

ph. 47-54 adv.

DR. WELLINGTON ADAMS.



Dr. Wellington Adams, a department editor of this publication, died in St. Louis, December 28, 1898.

Dr. Adams was born June 21, 1856, at Brooklyn, N. Y., and when a child was taken to Washington, D. C., by his widowed mother. For several years he was a page in the Senate, and often declared that he first grew ambitious by observing such men as Conklin, Grant and the other men of that time, who were seen about the national capitol. He attended a night school while in Washington, and later was sent to the Georgetown College, where he studied medicine. He remained in Washington to practice medicine a year, and then went to Colorado Springs. This was at a time when electrical appliances were just being perfected, and he took the keenest interest in them. He had developed into a specialist on the ear and nose, and got up several electric instruments of inestimable value to surgeons. His experiments in this direction led him to study electricity seriously, and it was then that his electric motor idea was given birth. He did not neglect his profession, however, and occupied a chair in a Denver medical college, and was made the secretary of the Colorado State Medical Society. From Colorado he went to Chicago, remained there two years, and in 1883 came to St. Louis.

Dr. Adams was known to St. Louisans better as an inventor than as a physician. He was the inventor of the present method of mounting a motor on a single axle in the construction of electric street cars. Later he began to foster the Chicago-St. Louis Electric Railway. The railway was to revolutionize traffic. A road-bed built on an air line between the two cities, the length of the State of Illinois, was to carry electric cars, which, by their peculiar construction, would make the distance between the two cities in a little over two hours. It was to cost about $8,000,000, and half of that sum was subscribed when the panic of 1893 came and money tightened and ruined the prospects of the ambitious scheme. Those unacquainted with Dr. Adams might have called him a dreamer, but those who did know him never considered him as such. He was of that class of inventors who, in spite of their boldness, are exceedingly practical in applying their ideas and working out the details of them.